
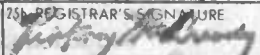


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

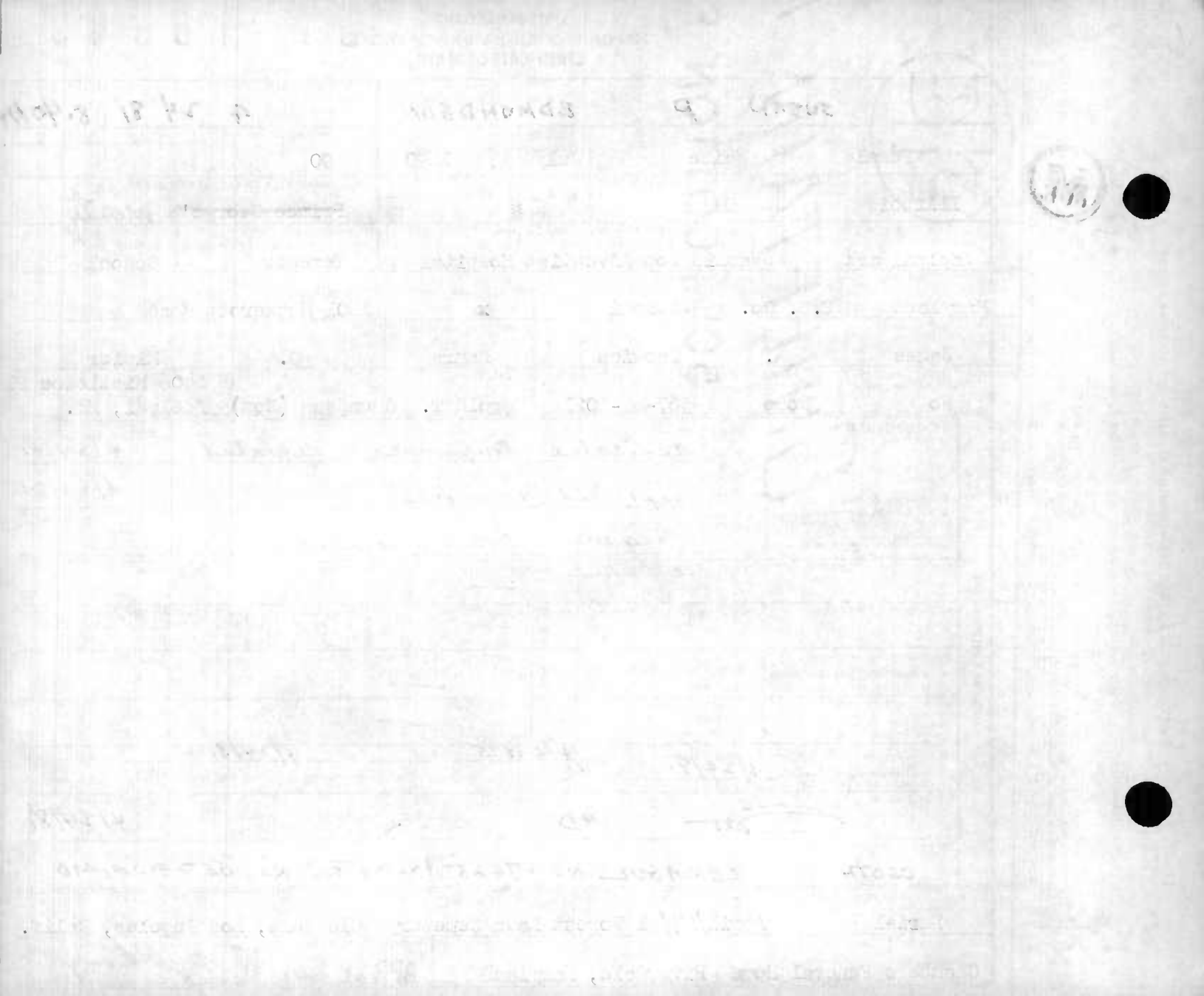
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |  |   |  |
|--|--|---|---|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>SUSAN P EDMUNDSON</b>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 24 81</b>   |  |  |  |   |  |
| 1. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 7 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's Mary MD.</b>              |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |   |   | 13b. COUNTY<br><b>P.G. Co.</b>   |  | 13c. CITY OR TOWN<br><b>Adelphi</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James A. Parkins</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura G. Minier</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |   | 17. INFORMANT<br><b>Harold T. Edmundson (Son)</b>   |  | ADDRESS<br><b>2406 Mistletoe Pl Adelphi, Md.</b>                                     |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>aspirated Pneumonia, repeated</b><br>5070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>aspirated Pneumonia</b><br>4/24/81<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Organic Brain syndrome</b><br>4/21/81<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b> |  |   |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1975</b> , 19____, to <b>4/24/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/24/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br> <b>MD</b>  |  |   |   |   | DEGREE<br><b>MD</b>  |  |  | 22c. DATE SIGNED<br><b>4/24/81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSOOTH LEKAGUL MD</b>  |  |   |   |   | 22e. ADDRESS<br><b>7425 ARLINGTON RD, BETHESDA, MD</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>April/27/81</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Lawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glendale, Los Angeles, Calif.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Chambers Funeral Home Riverdale, Maryland</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 30 1981</b>  |  |  |  |   |  |

BP

BHMH - 16 50M 1/B1  
(VRA 15, 4)



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 10844   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Josephine H. Ellis</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>4/17 19 81</b> |  |
| 3. SEX <b>Female</b> 4. RACE <b>Black</b> 5. DATE OF BIRTH (MONTH DAY YEAR) <b>Mar. 8, 1914</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>67 YRS.</b> 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 7c. DATE PRONOUNCED DEAD <b>4/17 19 81</b>   |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>12:20 P. M.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>   |  |  |  |  |  |  |  |  |  | 2d. HOUR <b>12:20 P. M.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cafeteria workder</b> 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>DC</b> 13b. COUNTY <b>Washington, D.</b> 13c. CITY OR TOWN <b>Washington, D.</b> 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>3924 - 5th Street, N. W.</b> 13e. STREET ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Charles H. Davis</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Carrie L. Smothers</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>579-24-5399</b> 17. INFORMANT ADDRESS <b>3916 Hampden St. Kensington, Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>multiple myeloma.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>2030<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos.</b>                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>None</b> 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>None</b> 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>4/22/81</b>  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b> ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>4-23-81</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Montg. Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b> ADDRESS <b>246 N. Washington St. Rockville, Md. 20850</b> 25a. DATE REC'D. BY REGISTRAR <b>APR 28 1981</b> 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreary</b>   |  |  |  |  |  |  |  |  |  |  |  |



California Highway

Charles L. Davis

Charles L. Davis

3210 Madison St.  
Little Rock, Arkansas 72201

670-24-230

No

1117 N. Norton, Tampa, Fla.

State of Nevada

4-13-71

Burial

George J. Spence, Jr., d. 2000



19

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

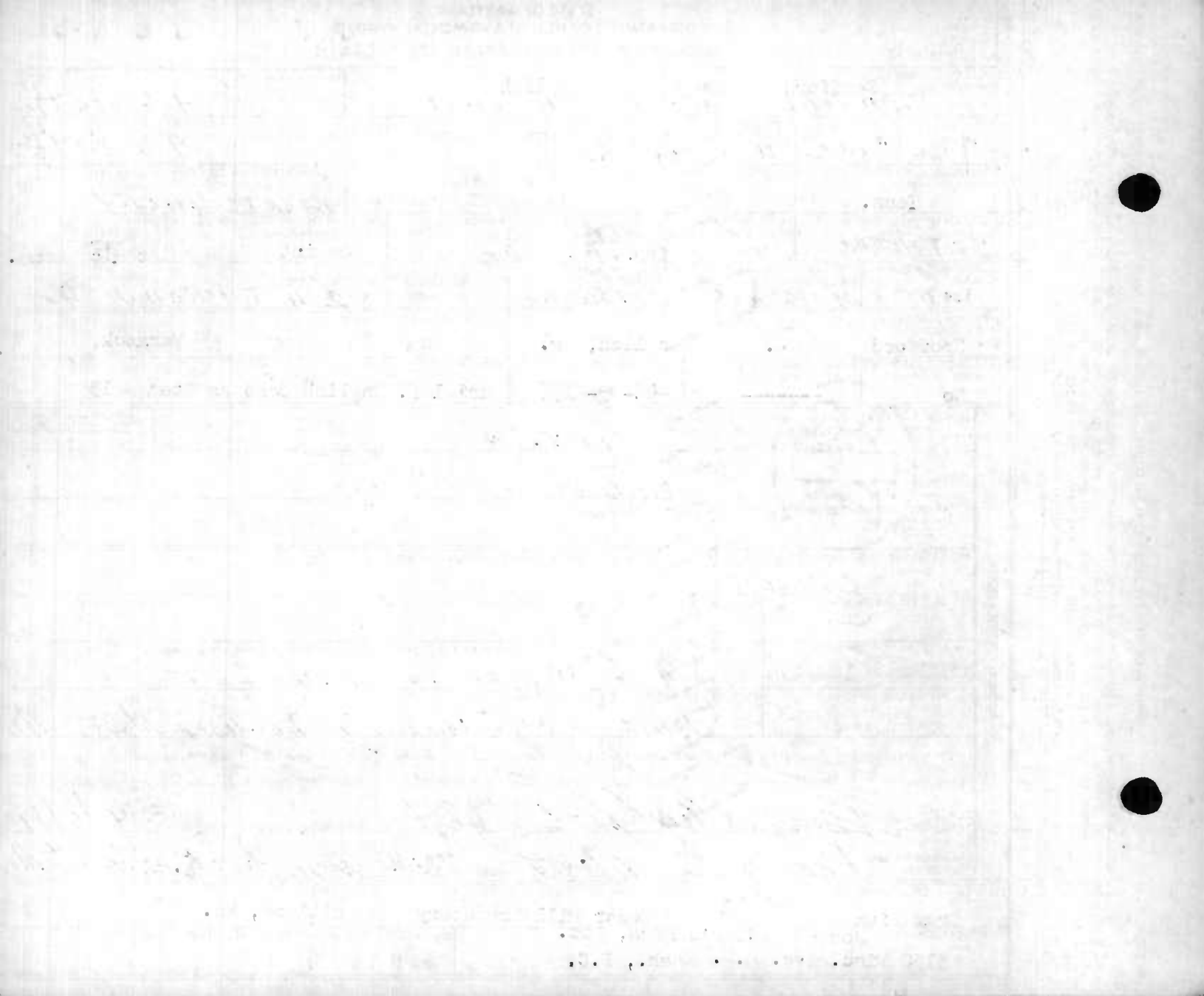
REG. NO.

10845

|  |                         |  |   |   |                                      |   |   |  |   |   |
|--|-------------------------|--|---|---|--------------------------------------|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Spofford Grady English</b><br><b>SPOFFORD GRADY ENGLISH</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>46 19 81</b> |   |                                      | 2b. HOUR <b>4 1/2 PM</b>  |   |  |   |   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 16 15</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>65 YRS.</b>   | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.       | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>46 19 81</b>                      |   |  | 2d. HOUR <b>4 1/2 PM</b>                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tenn.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                   |   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8204 THOREAU Dr</b> |   |   |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chemist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Atomic Comm.</b> |   |   |
| 13a. STATE<br><b>MD</b>  |                         |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN<br><b>BETHESDA</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS<br><b>8204 THOREAU Dr</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Spofford G. English, Sr.</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruby May Warnock</b>                                |   |                                      |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>446-05-0136</b>  |   | 17. INFORMANT ADDRESS<br><b>Muriel F. English Same as Item # 13</b>   |                                      |   |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIA</b><br><b>9530</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>DEPRESSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                         |  |   |   |                                      |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>CANCER</b>   |                         |  |   |   |                                      |   |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>—</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>—</b>  |   |   |                                      |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>4 6 19 81</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>HUNG IN BASEMENT</b>  |                                      |   |   |  |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>8402 THOREAU Dr BETHESDA MONT. MD</b>   |                                      |   |   |  |   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |   |                                      |   |   |  |   |   |
| ACTUAL SIGNATURE<br><b>Francis C. Mayle</b>  |                         | TITLE (SPECIFY)<br><b>Dept</b>   |   | M.D. <b>Dept</b>  |                                      |   | MEDICAL EXAMINER<br><b>Francis C. Mayle</b>   |  |   | DATE SIGNED<br><b>4/6/81</b>                  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Francis C. Mayle</b>   |                         | ADDRESS<br><b>8200 Wisconsin Ave BETHESDA MD</b>   |   |   |                                      |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |                         | 23b. DATE<br><b>4/8/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |                                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Md.</b>                              |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b>  |                         |  |   | ADDRESS<br><b>5130 Wisc. Ave. N.W. Wash., D.C.</b>  |                                      |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey M. Crumley</b> |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |   |                       |  |
|---|--|--|--|---|--|---|---|---|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDWARD L. EVERITT  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>34 7 81                         |   |  | 2b. HOUR<br>5: P M  |   |   |                       |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>December 22, 1905   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>75 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CT. MD.  |   |   |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Doctor  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical  |                       |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Bethesda  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John A. Everitt   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gustie Whitehead      |   |  | 13e. STREET ADDRESS<br>8515 Irvington Avenue  |   |   |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>578-44-1266                                |   | 17. INFORMANT<br>Helen F. Everitt  |   |   |   | ADDRESS<br>Same as 13 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septicemia</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>POST RADIATION PANCYTOPENIA</u><br>(c) <u>GLAT CELL CARCINOMA RIGHT LUNG.</u> |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerotic Heart Disease</u> <u>Angina Pectoris</u>   |  |  |  |   |  |   |   |   |                       |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1977</u> to <u>4-7-81</u> , that (I) (we) lost saw the deceased alive on <u>4-7-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |   |  |   |   |   |                       |  |
| 22b. SIGNATURE<br>Roland Imperial MD  |  |  |  |   |  | DEGREE<br>MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4-7-81  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROLAND IMPERIAL MD   |  |  |  |   |  | 22e. ADDRESS<br>4977 BATTERY LANE MD 20014  |   |   |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>April 10, 1981  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Cemetery                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville Maryland                                |   |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME Robert A. Pumphrey<br>Homes, P.A. Bethesda, Maryland   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1981  |   |   |                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

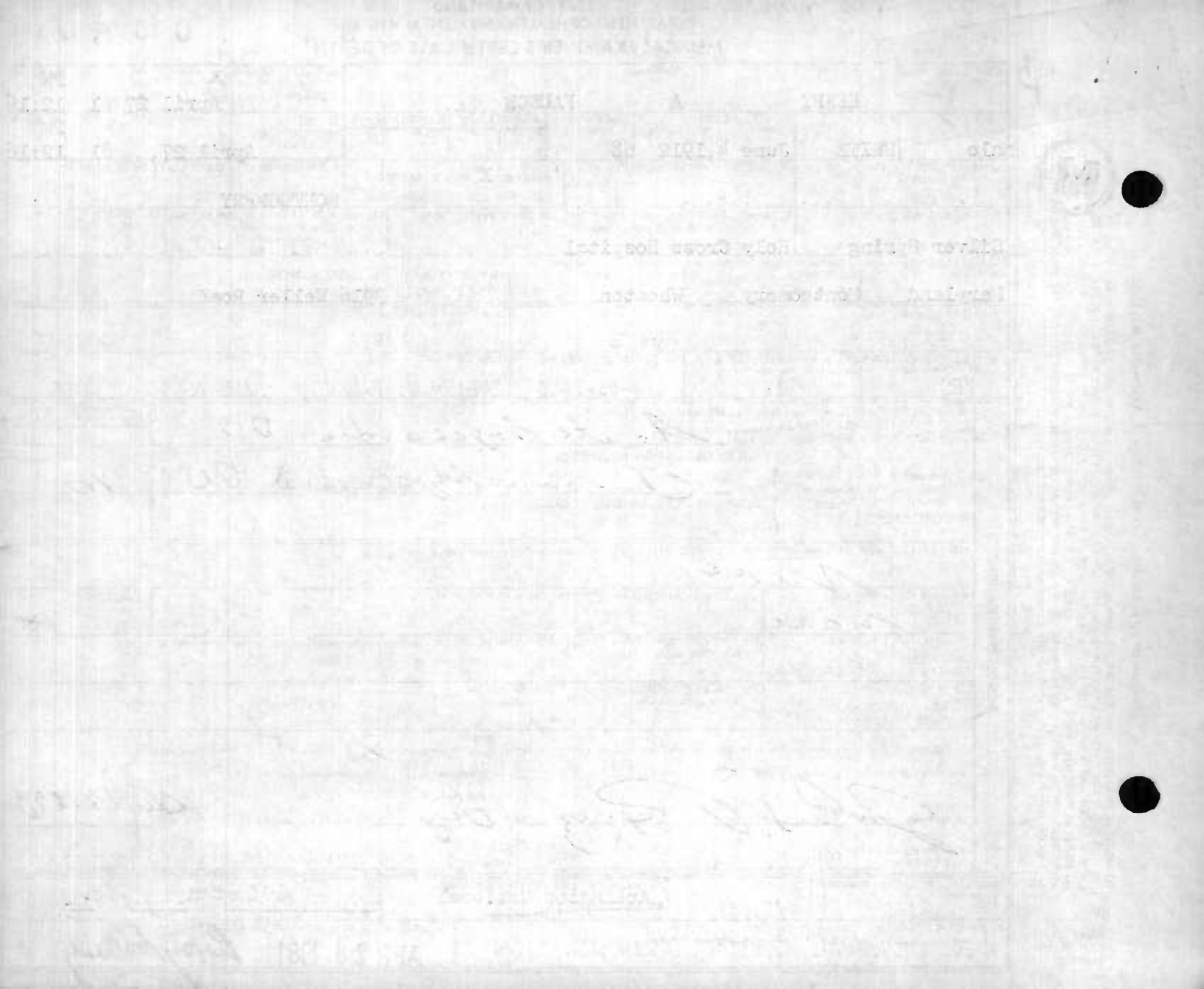
1954

1954

1954

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 10847  |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1- STATE REGISTRAR   |  |  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HENRY A FAUNCE Sr.  |  |  |  |   |  | 2a. DATE KNOWN OF ESTI- MATED<br>April 27 1981  |  | MONTH DAY YEAR   |  | PM HOUR   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>WHITE                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 4, 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY   |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STEAM FITTER 'LOCAL UNION 602 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery              |  | 13c. CITY OR TOWN<br>Wheaton  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3916 Weller Road  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE FAUNCE  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIA GOODING  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |  |  | 16b. SOCIAL SECURITY NO.<br>WW II 214-05-1620   |  | 17. INFORMANT<br>EVELYN M. FAUNCE   |  |  |  | ADDRESS<br>SAME AS 13 WIFE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4291 IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Chronic Myocardial Dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Yrs |  |  |  |   |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>None</u>   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><u>None</u>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><u>John S. Rogers</u>  |  |  |  | TITLE (SPECIFY)<br>M.D. <u>Dep</u>  |  |   |  | MEDICAL EXAMINER<br>DATE <u>April 27 1981</u><br>SIGNED  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) JOHN S. ROGERS  |  |  |  | ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  |  |  | 23b. DATE<br>4/30/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National GATE OF HEAVEN   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 28 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry K. Brady</u>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked occurred, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR<br>1 - STATE<br>REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. <u>150848</u><br><u>8-10-81</u>   |  |   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Fay Fauerstein</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-30-81</b>   |  |  |  | 2b. HOUR<br><b>11:45</b> M                      |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-16-15</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  |   |  |
| 13a. STATE<br><b>Florida</b>  |  | 13b. COUNTY<br><b>Broward</b>   |  | 13c. CITY OR TOWN<br><b>Lauderhill</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5021 N.W. 22nd Street</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David ----- Schreer</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna ----- Smith</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>064-07-1642</b>   |  | 17. INFORMANT<br><b>Silver Spring, Md.<br/>Alan R. Lovinger; 2310 Falling Creek Rd.</b>   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>4275<br>OR AS A CONSEQUENCE OF<br>(b) <b>either Acute M.I.</b><br>OR AS A CONSEQUENCE OF<br>(c) <b>pulmonary Arrest</b><br>DUE TO OR AS A CONSEQUENCE OF                  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Acute asthma</b>   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 21g. I certify that (If this hospital) attended the deceased from <b>4-29-81</b> , 19____, to <b>4-30-81</b> , 19____, that I (we) lost<br>saw the deceased alive on <b>4-30-81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we (did) did not view the body after death) |  |   |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Charles L. Frank, Jr.</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-30-81</b>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles L. Frank, Jr. MD</b>  |  |   |  | 22e. ADDRESS<br><b>11200 Lockwood Dr. Silver Spring Md 20911</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/3/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Star of David Mem. Pk., Pompano Beach, Fla.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry H. H. H.</b>   |  |  |  |   |  |

BP



THE UNIVERSITY OF CHICAGO  
LIBRARY



*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "University" and "Chicago" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  | REG. NO.                                  |  |
|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 7 1 10849  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                  |  |
| DAVID   |  |  | 4/17/81  |  | 1:30 P.M.                                 |  |
| 3. SEX  |  | 4. RACE  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)           |  |
| Male  |  | White  | 8 18 93  |  | 87 YRS.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH      |  |
| POLAND  |  | U.S.A.   |  |  | MONTGOMERY MD.                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Rockville   |  | 6111 Montrose Road   |  | MASTER FURRIER   |   | DESIGNER & MANUFACTURER  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                       |  |
| Md.   |  | Mont.  | Rockville  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 6111 Montrose Rd.                         |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  |   |  |
| SCHMUEL   |  |  | RYWKA JOSIE  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  |  | ADDRESS                                   |  |
| NO  |  | NONE   | ALFRED I. FIKS   |  | 220 N. Columbus St. Alexandria, Va. 22314 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) 4380 Uremia, Irreversible.  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure   |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
|   |  | P.M. 19  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |
|   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 11, 1979, to April 17, 1981, that (I) (we) lost  |  |  |  |  |   |  |
| saw the deceased alive on April 14th, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) visit the body after death. |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |   |  |
| James E. Wilson, Jr., M.D.  |  | FOR DR. WILFRED EHRLMANTZ  |  | 4/17/81  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |   |  |
| JAMES E. WILSON, JR., M.D.  |  | 11125 Rockville Pike Rockville, Maryland 20852   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| BURIAL  |  | APR. 21, 1981  | MONTEFIORE CEMETERY  |  | ST. ALBANS N.Y.                           |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |   |  |
| DANZANSKY-GOLDBERG  |  | ROCKVILLE, MD.   |  | APR 22 1981  |   |  |
| MEMORIAL CHAPELS, INC.  |  | 1170 ROCKVILLE PIKE  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |
|   |  |  |  | [Signature]  |   |  |

1950

1950

1950

75

75

75

75

75

75

x

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

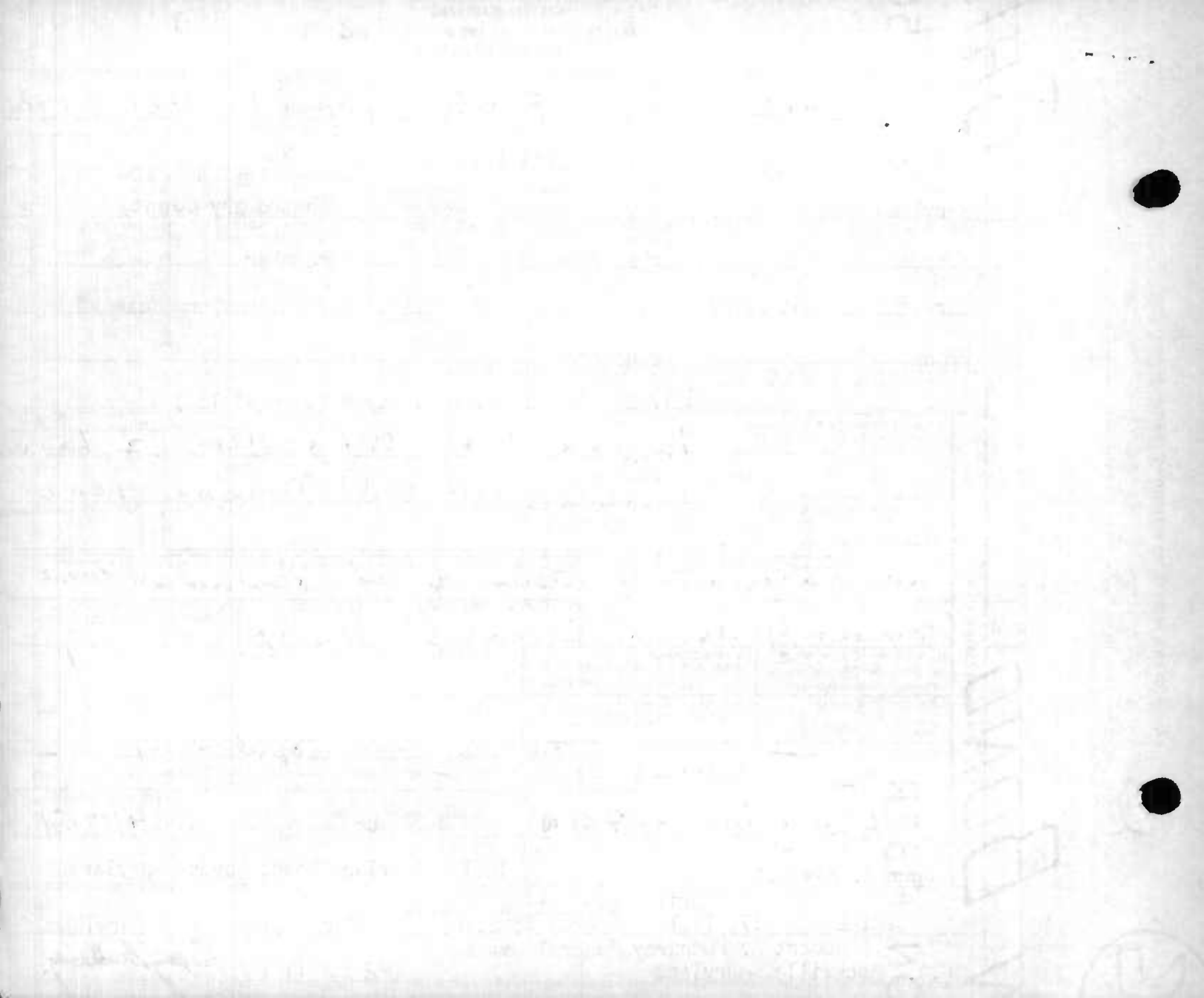
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |   |
|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PEARL L. FINK</b>  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 14 1981</b>   |  | 7b. HOUR<br><b>6:30 PM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 16, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                            |
| 10. CITY OR TOWN OF DEATH<br><b>Boysd</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>20920 Clarksburg Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Boysd</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Webster</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>217-28-8632</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sharon D. Gynn (Same as 13e)</b>                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic C.V. Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 hours</b><br>ADENOCARCINOMA OF UTERUS & ENDOMETRIAL CELL CARCINOMA |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>adenocarcinoma of uterus &amp; endometrial cell carcinoma</b>   |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>March 24, 81</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Vaginal Bleeding</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>30 July 1956</b> to <b>April 14 1981</b> , that (I) <del>was</del> lost saw the deceased alive on <b>April 14 1981</b> , and that in my <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death.   |   |   |  |   |
| 22b. SIGNATURE<br><b>John G. Fawcett</b>  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/14/81</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John G. Fawcett</b>   |   | 22e. ADDRESS<br><b>16610 Sugarland Road, Boysd, Maryland</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>April 17, 1981</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Germantown Baptist Church Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Germantown Maryland</b>                        |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>   |   | ADDRESS<br><b>Funeral Homes, P.A., Rockville, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1981</b>   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b>  |  |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                     |  |  |   |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                              |  |   |  |  |  |   |  |  |  | REG. NO. 10851             |  |
|--|--|---------------------|--|--|---|---|--|--|--|---|--|---|--|--|--|---|--|--|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dennis T. Finnegan</b>  |  |                     |  |  |   |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>4/21/1981</b> |  |   |  |  |  |   |  |  |  | 2b. HOUR <b>4:18p</b>      |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>cauc</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10/18/29</b>   |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>51</b>                 |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. <b>51</b>   |  | 7c. DATE PRONOUNCED DEAD <b>4/21/1981</b>   |  | 2d. HOUR <b>4:18p</b>   |  |  |  |   |  |  |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>  |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.                   |  |  |  |   |  |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda, Md.</b>   |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Switch Board Operator</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |  |  |                            |  |
| 13a. STATE <b>MD</b>   |  |                     |  |  |   |   |  |  |  | 13b. COUNTY <b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN <b>ROCKVILLE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>12110 PORTREE RD</b> |  |  |  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Dennis J. Finnegan</b>   |  |                     |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Sarah . Fallon</b> |   |  |  |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>   |  |                     |  | 16b. SOCIAL SECURITY NO. <b>198-22-5138</b>  |   | 17. INFORMANT ADDRESS <b>Mary T. Shannon same as 13e</b>          |  |  |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br><b>(b) ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(c)</b>  |  |                     |  |  |   |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Acute</b><br><b>10 YRS</b>                |  |   |  |  |  |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>ALCOHOLISM</b>   |  |                     |  |  |   |   |  |  |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| 19a. DATE OF OPERATION   |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |                            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                     |  | 21b. TIME OF INJURY<br>HOUR:AM. MONTH DAY YEAR <b>1 P.M. 4 21 1981</b>   |   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>FOUND DEAD IN BED</b>  |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>12110 PORTREE RD ROCKVILLE MONT MD</b>   |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                     |  |  |   |   |  |  |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| ACTUAL SIGNATURE <b>Francis C. Mayle</b>   |  |                     |  | TITLE (SPECIFY) <b>Deputy</b>  |   |   |  | DATE SIGNED <b>4/21/81</b>   |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayle</b>  |  |                     |  | ADDRESS <b>200 Wisconsin Ave Bethesda MD</b>   |   |   |  |  |  |   |  |   |  |  |  |   |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                     |  | 23b. DATE <b>4/24/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b> |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Maryland</b>                                    |  |   |  |  |  |   |  |  |  |                            |  |
| 24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>  |  |                     |  |  |   |   |  |  |  | 25a. DATE SPEC'D. BY REGISTRAR <b>APR 21 1981</b>   |  |   |  |  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |
| 1331 Rockville Pike Rockville, Maryland  |  |                     |  |  |   |   |  |  |  |   |  |   |  |  |  |   |  |  |  |                            |  |

1531 Rockville Ave. Rockville, Maryland  
 1000 Wheeler Rental Home, Inc.  
 Date of Death: 11/11/81  
 Date of Death: 11/11/81  
 Date of Death: 11/11/81

Francis G. Davis

100-22-2138  
 Mary E. Shannon same as 100-22-2138  
 100-22-2138

100-22-2138  
 100-22-2138  
 100-22-2138

100-22-2138  
 100-22-2138  
 100-22-2138



12  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 8 5 2

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Eugene J. Fischmann  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 24, 1981   |  | 2b. HOUR<br>8:05PM   |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 15, 1908   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Hungary  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br>Potomac  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10817 Admirals Way |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Physician                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medicine  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Potomac  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>10817 Admirals Way  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ralph Fischmann   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Hertzbrunn                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>579-64-6012  | 17. INFORMANT<br>ADDRESS<br>A. Betty Fischmann, Same as #13                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u><br>1889<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of Urinary Bladder</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 mos<br>16 mos |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> , 19 <u>80</u> , to <u>4/24</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>G. Lennard Gold, M.D.</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>4/25/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Lennard Gold  |   | 22e. ADDRESS<br>8630 Fenton St. Silver Spring, Md.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |   | 23b. DATE<br>April 27 1981  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland  |   | 25. DATE RECEIVED BY REGISTRAR<br>APR 30 1981   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |



1914-1915

1914-1915

1914-1915

1914-1915

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8

1

1

0

8

5

3

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |  |   |  |   |   |  |
|---|--|---|--|--|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MURIEL S FISHER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>21</b> YEAR <b>81</b>                       |  |   | 2b. HOUR<br><b>4:15 PM</b>   |   |  |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>06</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. <input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MONT CO., MD.</b>  |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>10201 GROSNER PLACE</b> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>HERCHEL</b> MIDDLE <b>SLATER</b> LAST <b>WALKER</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>FANNY</b> MIDDLE <b>WALKER</b> LAST <b>WALKER</b> |  |   |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-22-8715</b>   |  | 17. INFORMANT<br><b>SON</b>                                     |  |   | ADDRESS <b>13709 MARIANNA DR. ROCKVILLE, MARYLAND</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Small Cell Bronchogenic Carcinoma</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE, PNEUMONITIS, EMPYEMA</b>   |  |   |  |  |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>4/18/81</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Diagnostic Thoracotomy</b>      |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/8</b> 19 <b>81</b> , to <b>4/21</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/21</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Bernard A. Fitzgerald</b>  |  |   | DEGREE <b>MD</b>   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>4-21-81</b>                |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD A. FITZGERALD</b>   |  |   | 22a. ADDRESS<br><b>217 UNIVERSITY BLVD E, SILVER SPRING, MD</b>                        |  |   |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |   | 23b. DATE<br><b>4/24/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARLINGTON VIRGINIA</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br>ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |  |

MEDICAL CERTIFICATION

April 18 1901

(M)

APR 18 1901

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |   |  |   |  |   |  | REG. NO. 10854  |  |
|--|------------------|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frieda Fitzpatrick</b>  |                  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>April 5, 1981</b>                                       |  | 2b. HOUR <b>5:15</b> M  |  | 2c. DATE PRONOUNCED DEAD <b>April 5, 1981</b> M                                     |  |
| 3. SEX <b>F</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Oct. 30 1961</b> |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>61</b> YRS.                 |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>          |  | 10. CITY OR TOWN OF DEATH<br><b>S. L. Spg</b>                     |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp</b>                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAITRESS</b>    |  |
| 13a. STATE<br><b>MD</b>  |                  | 13b. COUNTY<br><b>Montgomery</b>                       |  | 13c. CITY OR TOWN<br><b>S. L. Spg</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>15181 Peach Orchard Dr</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE <b>GEORGE WETTERAUER</b>   |                  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE <b>ANNA CHRIST</b>                                     |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) <b>NO</b>  |                  |  |  | 16b. SOCIAL SECURITY NO.<br><b>296-03-2688</b>                    |  | 17. INFORMANT <b>HUSBAND</b> ADDRESS<br><b>JOSEPH V. FITZPATRICK, SR. SAME AS 13</b>            |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>Arteriosclerotic Cardiac Vas. Dis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4292</b>  |                  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |                  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |                  |  |  | TITLE (SPECIFY)<br><b>M.D. Depr</b>                               |  |   |  | DATE SIGNED<br><b>April 5, 1981</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>JOHN S. ROGERS</b>   |                  |  |  | ADDRESS<br><b>1919 SEMINARY RD., SILVER SPRING, MD.</b>           |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                  | 23b. DATE<br><b>4/8/81</b>                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT MD.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br>ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |                  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 06 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert [Signature]</b>   |  |   |  |



APR 10 1981  
1881 00 292



DHMM 16-50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral home.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lamar J. FOWLER</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 22 1981</b>                             |   |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 30 1918</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>  |  | 7b. HOUR<br><b>3:30A</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. Coast Guard</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Parkville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lester Fowler</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Barrett</b>                |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>1934-58</b>  |  | 17. INFORMANT ADDRESS<br><b>Michael J. Fowler 1510 Maplewood Drive</b>  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 13</b> 19 <b>81</b> , to <b>April 22</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>April 22</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Gary G. Sladek</b> M.D.  |  |   |  |   | 22c. DATE SIGNED<br><b>Apr. 23 1981</b>  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary G. Sladek, M.D.</b> |  |  |
| 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>   |  |   |  |   | 22f. DATE REC'D. BY REGISTRAR<br><b>APR 23 1981</b>                                  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/27/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Arlington Va.</b>                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. Collins</b>   |  | 24b. FUNERAL HOME<br><b>Collins Funeral Home</b>  |  | 24c. ADDRESS<br><b>500 UNIV. BLVD., W Silver Spring, Md.</b>  |  | 24d. SIGNATURE<br><b>Francis J. Collins</b>   |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |   |  | REG. NO. 81 10856  |  |
|--|--|---|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LOUIS FREED</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 7 81</b>                   |  |  | 2b. HOUR<br><b>10:AM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 30 10</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>                         |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CAB DRIVER</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRIVATE</b>   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |  |  |   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8622 11th AVENUE</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>IGNATZ FREED</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>EDITH ISKOWITZ</b> |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>MISS SHERRY FREED, same as #13</b>  |   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Urinary Tract Infection</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Unknown ? Hepatic Coma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b><br><b>2 WEEKS</b><br><b>4 days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ACUTE RENAL FAILURE - 2 WEEKS</b>   |  |   |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/13/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>UNSTABLE ANGINA</b>  |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF DEATH HOUR A.M. MONTH DAY YEAR<br><b>10 P.M. 4/7 1981</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |  |  |   |  |  |  |
| 22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>2/16/81</b> , 19____, to <b>4/7/81</b> , 19____, that (I) <del>we</del> lost saw the deceased alive on <b>4/7/81</b> , 19____, and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) (did not) view the body after death. |  |   |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE <b>RD BIANCO</b> MD   |  |   |  |   |   | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RDIBIANCO</b>   |  | 22e. ADDRESS<br><b>CARDIO. DIV. WASH ADV. HSP. 7600 CARROLL AVE TAKOMA PK</b>                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/8/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHAV ZEDECK CEMETERY</b>   |   |  |  | 23d. NAME OF CEMETERY OR CREMATORY<br><b>MANOVER TOWN SHIP LUZERNE COUNTY, PENNSYLVANIA</b>                             |  |  |  |
| 24. DONATED TO OR BY<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>   |  |   |  |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>APR 10 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard...</i>   |  |  |  |

*[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side. Some faint words like "UNITED STATES" and "DEPARTMENT OF" are visible.]*

APR 10 1961

FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |                        |                       |  |  |   |  |   |                            |   |  |   |  |   |   |  |  |  |  |  |  |
|---|--|------------------------|-----------------------|--|--|---|--|---|----------------------------|---|--|---|--|---|---|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |  |                        | First<br><b>AARON</b> |  |  | Middle<br><b>FRIEDENBERG</b>  |  |   | Last<br><b>FRIEDENBERG</b> |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Month Day Year<br><b>4 11 1981</b> |  |   | 2b. HOUR<br><b>2:07 PM</b>                      |  |  |  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>Cauc</b> |                       | 5. DATE OF BIRTH<br><b>4/28/04</b>   |  | 6. AGE (In years last birthday)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                            | IF UNDER 24 HRS<br>HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>4 11 1981</b>  |  |   | 2d. HOUR<br><b>2:07 PM</b>                      |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD</b>  |  |                        |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |                            |   |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md  |  |   |   |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>   |  |                        |                       |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>COLLINGS WOOD NURSING HOME</b> |  |   |                            |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LAWYER</b>    |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>IRS</b> |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  |  |                        |                       |  |  | 13b. COUNTY<br><b>MONTGOMERY CHEVY CHASE</b>  |  |   |                            |   |  | 13c. CITY OR TOWN<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>      |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |  |  | 13e. STREET AND NUMBER<br><b>4603 DORSET AVE</b> |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>NATHAN FRIEDENBERG</b>   |  |                        |                       |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>SARAH</b>   |  |   |                            |   |  |   |  |   |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>  |  |                        |                       |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>082-22-2856A</b>                          |  |   |                            |   |  | 17. INFORMANT<br>ADDRESS<br><b>FLORENCE FRIEDENBERG (WIFE) CHEVY CHASE, MD</b>                              |  |   |   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br><b>8880</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HEAD &amp; FACIAL INJURIES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>FALL</b>  |  |                        |                       |  |  |   |  |   |                            |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 wks</b><br><b>1 1/2 mo</b><br><b>1 1/2 mo.</b>       |  |   |   |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>PARKINSONISM</b>   |  |                        |                       |  |  |   |  |   |                            |   |  |   |  |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  |                        |                       |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |   |                            |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |   |   |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                        |                       | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>2 25 1981 P.M.</b>                        |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>BLOWN OVER BY WIND</b>  |                            |   |  |   |  |   |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                        |                       | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>LAKEFOREST MALL</b> |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>LAKEFOREST MALL GAITHERSBURG MONT. MD</b>  |                            |   |  |   |  |   |   |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                        |                       |  |  |   |  |   |                            |   |  |   |  |   |   |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Francis C Mayle Jr</b>   |  |                        |                       | EXAMINER'S NAME (Type)<br><b>FRANCIS C MAYLE JR</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                            |   |  | 22b. DATE SIGNED<br><b>4/11/81</b>  |  |   |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |                        |                       | 23b. DATE<br><b>13 APRIL 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WASH. HEBREW CONG. MEM. PARK</b>   |  |   |                            | 23d. LOCATION (City or Town) (County) (State)<br><b>WASHINGTON D.C.</b> |  |   |  |   |   |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>DANZANSKY-GOLDBERG MEM. CH., ROCKVILLE, MARYLAND</b>  |  |                        |                       |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 13 1981</b>   |                            |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John M. Cuddy</b>  |  |   |   |  |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-10, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

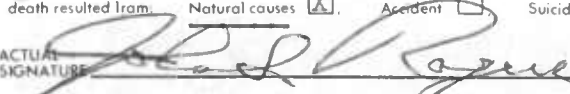
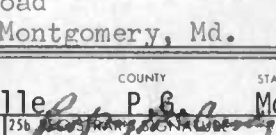
556  
YR NAME (5)  
BM 1/70



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |   |  |  |   |  | REG. NO. 10858   |  |
|--|--|----------------------|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |   |   |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Fay A. Friedman</b>  |  |                      |  |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>4/28 19 81</b>   |  | 2b. HOUR <b>A.</b>  |  |  |  |
| SEX <b>Female</b>  |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 15, 1912</b>        |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>                              |  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10001 Spring Street, #723</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOKKEEPER (Ret.)</b>       |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>OFFICE</b>                                  |  |
| 13a. STATE <b>Maryland</b>   |  |                      | 13b. COUNTY <b>Montgomery</b>  |   | 13c. CITY OR TOWN <b>Silver Spring</b>                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>10001 Spring Street, #723</b>                                       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN ROSEN</b>   |  |                      |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      | 16b. SOCIAL SECURITY NO. <b>053-20-9439</b>  |   |   | 17. INFORMANT (Husband) <b>SOL FRIEDMAN</b>  |  |   | ADDRESS <b>10001 Spring St., Silver Spring, Md.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>hypertensive heart disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |  |                      |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |   |  |  |   |  |  |  |
| ACTUAL SIGNATURE    |  |                      |  |   |   | TITLE (SPECIFY) <b>Deputy</b>  |  |   | DATE SIGNED <b>4/28/81</b>   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>  |  |                      |  |   |   | ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      | 23b. DATE <b>APR. 30, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Mem. Park</b> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyattsville P. 8 Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG</b> ADDRESS <b>ROCKVILLE, MD.</b>  |  |                      |  |   |   | 25a. DIRECTED BY REGISTRAR <b>MAY 1 1981</b>   |  |   | 25b.  |  |  |
| MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE   |  |                      |  |   |   |  |  |   |  |  |  |

(14)

COLLEGE  
LIBRARY  
1971



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                              |   |   |  |   |  |
|---|--|---|--|---|------------------------------|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Evelyn May Friedrich   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4/27/81                         |   |                              | 2b. HOUR<br>2:45 PM   |   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 16, 1903   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  |   | 7. NUMBER OF YEARS<br>HUSBAND<br>WIDOWED<br>DIVORCED   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10909 Amherst Street |  |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Woodward & Lothrop Manager          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Floor   |   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Wheaton |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Martin  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lottie Mae Turner     |   |                              | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>None |   |  |   |  |
| 16a. SOCIAL SECURITY NO.<br>577 01 4982   |  |   | 17. INFORMANT<br>William J. Friedrich (Husband)                        |   |                              | 18. ADDRESS<br>Same as Above  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>4960 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic obstructive pulmonary disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 years</u> |  |   |  |   |                              |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                              |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>March</u> , 19 <u>79</u> , to <u>April 27</u> , 19 <u>81</u> , that (I) <u>last</u> saw the deceased alive on <u>April 25</u> , 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |  |   |                              |   |   |  |   |  |
| 22b. SIGNATURE<br>Seruch T. Kimble M.D.   |  |   | DEGREE   |   |                              | 22c. DATE SIGNED<br>4-27-81   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 22d. FUNERAL DIRECTOR<br>NAME<br>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.  |  |   | 22e. ADDRESS<br>9801 Georgia Ave, Silver Spring, Md.                   |   |                              | 22f. REGISTRAR'S SIGNATURE<br>MAY 4 1981  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>4/30/81   |   |                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>S.S. Mont. Maryland |  |

noir et blanc

2931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  | REG. NO. |   |
|--|--|--|--|--|----------|---|
| 1. FOR STATE REGISTRAR   |  |  | 10860  |  |          |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH                            |  | 2b. HOUR |   |
| Lawrence G Frocke  |  |  | 4 24 81                                      |  | 2147M    |   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |          | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| MALE   |  | WHITE  |  | JUNE 10, 1908  |          | 72 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| MARYLAND   |  | U.S.A.   |  |  |          | Montgomery MD.  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Rockville  |  | Shady Grove Adventist Hospital   |  | ENGINEER   |          | RAILROAD, WASH. TERM.   |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |          | 13d. INSIDE CITY LIMITS?  |
| MARYLAND   |  | MONTGOMERY   |  | GERMANTOWN   |          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |  |          |   |
| ABRAHAM FROCKE   |  |  | FLORENCE STOTTLER                            |  |          |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |          |   |
| NO   |  | 719-01-2988  |  | THURZA L. FROCKE SAME AS 13 WIFE   |          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Mucosar Epidermoid Lung Carcinoma</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 months           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |          |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |          | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |          |   |
|  |  |  |  |  |          |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |          |   |
|  |  |  |  |  |          |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 4/24</u> , 19 <u>80</u> , to <u>4/24</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>4/24</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |  |          |   |
| 22b. SIGNATURE <u>For DR. S. NEWMAN</u> <u>MD, FCCP</u>  |  |  |  | 22c. DATESIGNED <u>4/25/81</u>   |          |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDWARD S. MEHLMAN</u>   |  |  |  | 22e. ADDRESS <u>5625 BRADLEY BLVD. BETHESDA, MD.</u>   |          |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |          | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |
| BURIAL   |  | 4/28/81  |  | PARK HEIGHTS CEMETERY  |          | BRUNSWICK FREDERICK MD.   |
| 24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |          | 25b. REGISTRAR'S SIGNATURE <u>History/Hebudy</u>                    |
| 400 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |  |  | APR 28 1981  |          |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |   |  | 81 10861   |  |
|--|---|---|---|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |   |   | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Jestina W. Furman</i>   |   |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>4 5 81</i>  |  | 7b. HOUR<br><i>12 noon</i>   |  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Cau</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 19 95</i>  | 6. AGE (IN YEARS-LAST BIRTHDAY)<br><i>86</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rockville</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Collingswood Nursing Center</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |  |
| 13a. STATE<br><i>Maryland</i>  | 13b. COUNTY<br><i>Montgomery</i>  | 13c. CITY OR TOWN<br><i>Kensington</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>9709 Elrod Rd.</i>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Jason P. Warthen</i>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Charlotte H. Reed</i>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |   | 16b. SOCIAL SECURITY NO.<br><i>578-46-8352</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Irene H. Warthen, 201 Russell Ave., Gaithersburg, Md.</i> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4280</i> <i>Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Approximate interval between onset and death: <i>2 days</i>                                    |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><i>Senility - senile dementia</i>   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 21</i> , 19 <i>81</i> , to <i>Apr 5</i> , 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>Mar 19</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Ira Paul Knefting</i>   |   | DEGREE<br><i>MD</i>   |   | 22c. DATE SIGNED<br><i>Apr 5 1981</i>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Ira Paul Knefting MD</i>   |   | 22e. ADDRESS<br><i>1811 Prince Philip Dr Olney MD 20832</i>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |   | 23b. DATE<br><i>Apr. 7, 1981</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Damascus Meth.</i>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Damascus, Montg. Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Olin L. Molesworth, P.A.,</i>   |   | ADDRESS<br><i>Damascus, Md.</i>   |   | 25. BY REGISTRAR<br><i>1981</i>  |  |  |

SECRET  
U.S. GOVERNMENT PRINTING OFFICE  
1964 O - 341-141



SECRET

20

page

SECRET

SECRET

SECRET

U.S. GOVERNMENT PRINTING OFFICE  
1964 O - 341-141



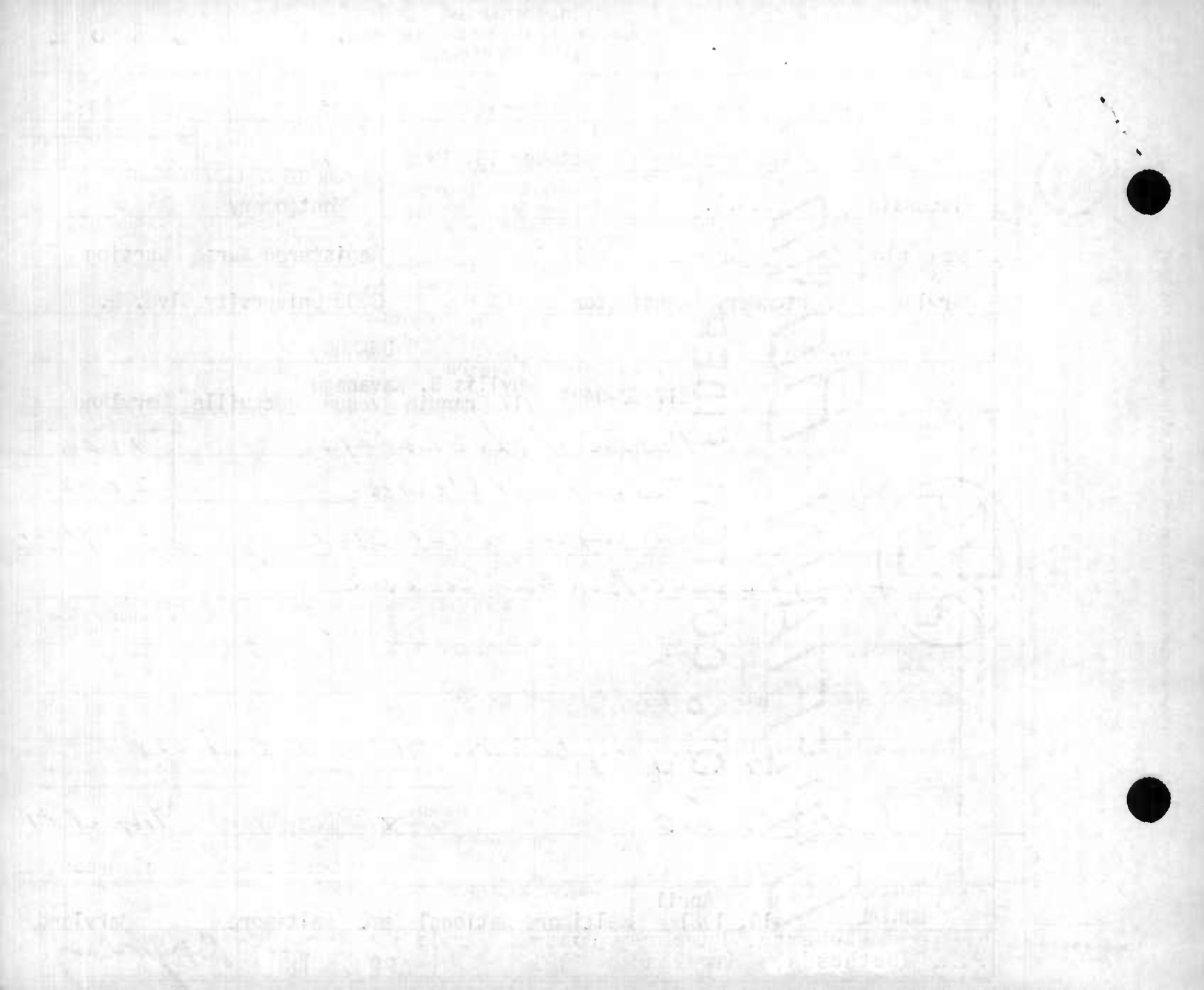
SECRET  
U.S. GOVERNMENT PRINTING OFFICE  
1964 O - 341-141



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |   |   |  |   | 1 0 8 6 2  |  |
|---|--|---|--|---|---|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |   |   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Florence Turner Garrett</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 6, 1981</b>     |   |   | 2b. HOUR<br><b>8:30</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 15, 1906</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Registered Nurse</b>     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b>                     |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Kensington</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3333 University Blvd. W.</b>   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b> |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-32-0494</b>                  |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Phyllis D. Kavanagh<br/>717 Grandin Avenue, Rockville, Maryland</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rupture of the Esophagus</b><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Esophageal Varices</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cutdown of the Tere</b> |  |   |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>2 weeks</b><br><b>2-3 years</b>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Lymphoproliferative Disorder</b>  |  |   |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 14, 1978</b> to <b>4 April 1981</b> , that (I) (we) lost saw the deceased alive on <b>4 April 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>E. P. Libre</b> DEGREE   |  |   |  |   |   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7 April 81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eugene P. Libre, M.D.</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>10400 Connecticut Ave. Kensington, MD</b>                                    |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>April 10, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>                            |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey<br/>P.A. Rockville, Maryland 20014</b>  |  |   |  |   |   | DATE REC'D. BY REGISTRAR<br><b>APR 20 1981</b>  |   |  | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                             |  |  |



REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |                         |  |                                |   |                            |  |  |
|---|--|---|-------------------------|--|--------------------------------|---|----------------------------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |                         | 2a DATE OF DEATH   |                                | MONTH DAY YEAR  |                            | 2b HOUR  |  |
| Ethel   |  | M. Alister Garrison   |                         | April 30, 1981   |                                | 8:40a   |                            |  |  |
| 3 SEX   |  | 4 RACE  |                         | 5. DATE OF BIRTH   |                                | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                            | 7 IF UNDER 1 YEAR  |  |
| Female  |  | white   |                         | Dec. 9, 1901 YEAR  |                                | 79  |                            | MONTHS DAYS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN)  |  | 7b CITIZEN OF WHAT COUNTRY?   |                         | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                            |  |  |
| Virginia  |  | USA   |                         |  |                                | Montgomery County MD  |                            |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                         |  |                                | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |                            | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| Olney   |  | Montgomery General Hospital   |                         |  |                                | H.Wife  |                            | Home   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |                         |  |                                |   |                            |  |  |
| 13a STATE   |  | 13b COUNTY  |                         | 13c CITY OR TOWN   |                                | 13d. INSIDE CITY LIMITS?  |                            | 13e STREET ADDRESS   |  |
| Maryland  |  | Mont.   |                         | Rockville  |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 16511 Cashell Road   |  |
| 14 FATHER'S NAME  |  |   |                         |  | 15 MOTHER'S MAIDEN NAME        |   |                            |  |  |
| FIRST MIDDLE LAST   |  |   |                         |  | FIRST MIDDLE LAST              |   |                            |  |  |
| Henry - McAlister   |  |   |                         |  | Fannie - McAlister             |   |                            |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b SOCIAL SECURITY NO. |  | 17 INFORMANT ADDRESS           |   |                            |  |  |
| no  |  |   | 212-74-8749             |  | John W. McAlister Same as # 13 |   |                            |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>MYOCARDIAL EVENT, ACUTE</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>ARTERIO SCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |                         |  |                                |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>SUDDEN</u><br><u>SUDDEN</u><br><u>YES</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>DIABETES</u> <u>HYPERTENSION</u>  |  |   |                         |  |                                |   |                            |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |                         |  |                                | 20a AUTOPSY?  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |
|   |  |   |                         |  |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                |   |                            |  |  |
|   |  |   |                         |  |                                |   |                            |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                         | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |                            |  |  |
|   |  |   |                         |  |                                |   |                            |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>Nov 5</u> 19 <u>68</u> , to <u>4/30</u> 19 <u>81</u> , that (1) (we) lost <u>know</u> the deceased alive on <u>4/30</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.   |  |   |                         |  |                                |   |                            |  |  |
| 22b. SIGNATURE<br><u>Donald E. Lewis</u>  |  |   |                         | DEGREE<br><u>MD.</u>   |                                |   |                            | 22c. DATE SIGNED<br><u>4/30/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald Lewis, M.D.   |  |   |                         | 22e ADDRESS<br>18101 Prince Philip Dr., Olney, Md.   |                                |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)  |  | 23b. DATE   |                         | 23c. NAME OF CEMETERY OR CREMATORY   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                            |  |  |
| BURIAL-Removal  |  | May 4, 1981   |                         | Mt. Moriah Church Cem.   |                                | White Hall, Albermarle, VA.   |                            |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Francis H. Barber Laytonville, Md. 20760   |  |   |                         |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE |  |  |
|   |  |   |                         |  | MAY 8 1981                     |   |                            |  |  |

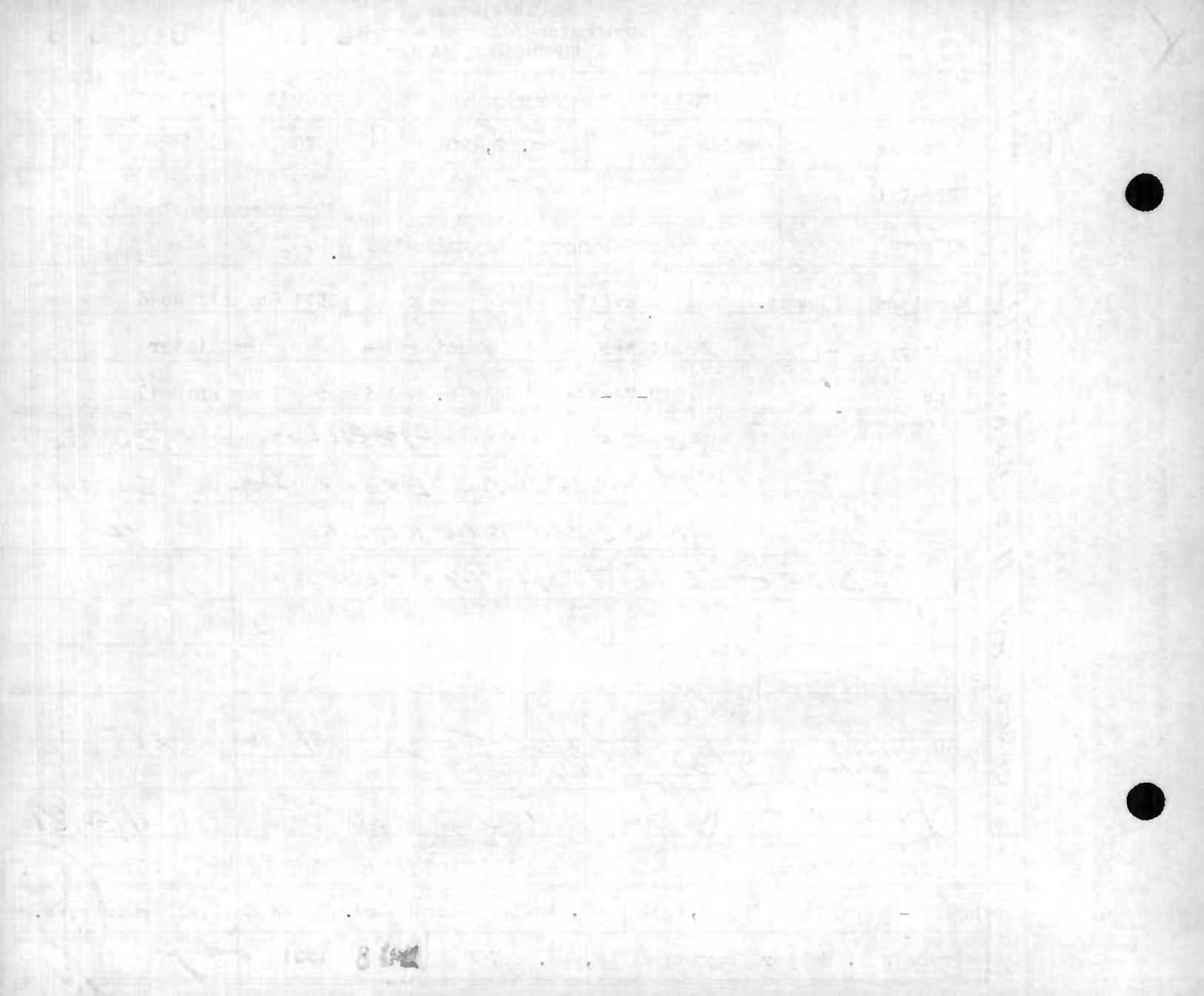
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CLEARED BY MED. EXAMINER

1301 BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO.   |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles Gendason</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 23, 1981</b>   |   |  | 2b. HOUR<br><b>4:00 PM</b>                                       |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 8, 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8201 16th St.</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PHYSICIAN</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRIVATE PRAC.</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8201 16th. Street, Apt. 416</b>        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX GENDASON</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATIE UNKNOWN</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. I.</b>   |  | 17. INFORMANT<br><b>SYLVIA GENDASON</b>   |  | ADDRESS <b>Baltimore, Md.</b><br><b>7922 Dunhill Village Cir.</b>                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Heart Disease</b><br>1943<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cancer of ascending Colon</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3-8-81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of Colon</b>  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-18-81</b> to <b>4-23</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4-17-</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Benjamin Manchester M.D.</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>APR. 23, 1981</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Benjamin Manchester, M. D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>106 Irving St. N. W, Washington, DC</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>APR. 24, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND P.G. MD.</b>                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>DANZANSKY-GOLDBERG</b> ADDRESS <b>ROCKVILLE, MD.</b><br><b>MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE</b>  |  |   |  |   |  |   |  |  |  |

RECEIVED  
JAN 10 1964  
U.S. DEPT. OF JUSTICE

IN RE: [illegible] [illegible] [illegible]

vs. [illegible]

FILE NO. [illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 8 6 5

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |   |   |   |   |   |                                  |
|--|--|---|---|--|--|---|---|---|---|---|----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>VINCENT L. GINAINE</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 9 81</b>                   |  |  | 2b HOUR<br><b>3 P</b> M   |   |   |   |   |                                  |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>white</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 4 1898</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |   | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                             |   | 7b IF UNDER 24 HRS<br>HOURS MIN<br><b>0 0</b> |                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                            |   |   |   |   |                                  |
| 10 CITY OR TOWN OF DEATH<br><b>Kensington</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kensington Gardens Nursing Home</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer Etna</b> |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Scientific Co.</b>                   |   |   |                                  |
| 13a STATE<br><b>Maryland</b>   |  |   | 13b COUNTY<br><b>Montgomery</b>                                       |  | 13c CITY OR TOWN<br><b>Bethesda</b>                          |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>9811 Wildwood Road 20014</b>   |   |                                  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jeremiah Ginaine</b>   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Lavin</b>  |  |   |   |   |   |   |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b SOCIAL SECURITY NO.<br><b>389-07-0268</b>                         |  |  | 17 INFORMANT ADDRESS<br><b>Judith Dighe daughter same as 13</b>                         |   |   |   |   |                                  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>uremia</b>   |  |   |   |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 mo</b>  |   |                                  |
| 4039 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic renal insufficiency</b>  |  |   |   |  |  |   |   |   | 5 yrs   |   |                                  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>nephrosclerosis &amp; recurrent UTI</b>   |  |   |   |  |  |   |   |   | 10 yrs  |   |                                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>stroke &amp; right hemiplegia</b>                            |  |   |   |  |  |   |   |   |   |   |                                  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   |                                  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |   |   |   |   |                                  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |   |                                  |
| 22a I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <b>4-5 1981</b> to <b>4-9 81</b> , that (I) last<br>above, (b) did (did not) view the body after death. |  |   |   |  |  |   |   |   |   |   |                                  |
| 22b SIGNATURE<br><b>G. Sengstack M.D.</b>  |  |   |   |  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br><b>4-9-81</b> |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. Sengstack, M. D.</b>   |  |   |   |  |  | 22e ADDRESS<br><b>9241 Columbia Blvd., Silver Spring, Md.</b>                           |   |   |   |   |                                  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b DATE<br><b>Apr. 13, 1981</b>                                      |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> |   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>St. Louis St. Louis Mo.</b> |   |   |                                  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Francis J. Collins<br/>500 University Blvd., W. Silver Spring, Md.</b>   |  |   |   |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>                                      |   | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                             |   |   |                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





CHICAGO, ILL.

1891

1892

1893

1894

1895

1896

1897

1898

1899

1900

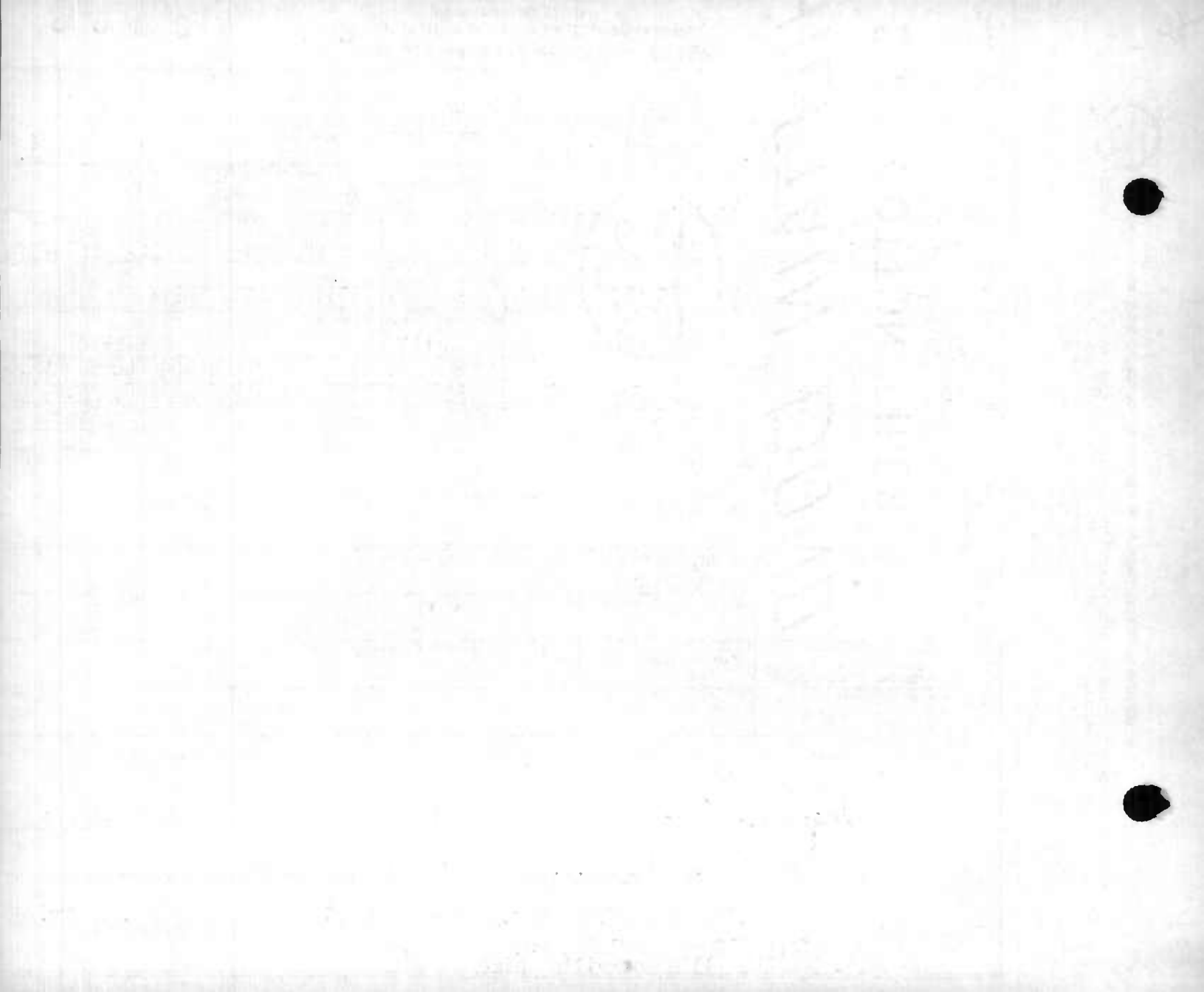
1901

1902

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | REG. NO. 10866  |  |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Harriet Michael Gitlitz  |  |   |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 14 19 81 |  |
| 3. SEX Female  |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR AUG. 17, 1931  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.                                 |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 14 19 81  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.              |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY |  | 12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE                                    |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALFRED MICHAEL   |  |   |  |  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SALLY GILVAR   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |  | (IF YES, GIVE WAR OR DATES) NONE  |  | 16b. SOCIAL SECURITY NO. 083-24-9498   |  | 17. INFORMANT (SON) DAVID GITLITZ                                       |  | ADDRESS 8904 FLOWER AVE., SILVER SPRING, MD. 20901                               |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4850 Bronchopneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fatty Liver   |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER   |  |  |  |   |  | DATE SIGNED 4-14-81  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  | ADDRESS 111 Penn Street   |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE Apr. 16, 81   |  | 23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEM. GARDENS   |  | 23d. LOCATION CITY OR TOWN Olney  |  | COUNTY Mont. STATE Md.   |  |   |  |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG   |  | ADDRESS ROCKVILLE, MD. MEMORIAL CHAPELS 1170 Rockville Pike   |  | 25a. DATE REC'D. BY REGISTRAR APR 20 1981  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |                           |  |   |  |
|---|--|---|--|---|--|--|---------------------------|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | CERTIFICATE OF DEATH   |  |                           |  |   |  |
| 1. DECEASED NAME  |  |   |  |   | 2a. DATE OF DEATH  |  |                           |  |   |  |
| FIRST MIDDLE LAST   |  |   |  |   | MONTH DAY YEAR HOUR  |  |                           |  |   |  |
| George T. Glorius, Sr.  |  |   |  |   | 4 3 1981 2:10P M   |  |                           |  |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS, LAST BIRTHDAY)   |                           | 7. IF UNDER 1 YEAR   |   |  |
| Male  |  | Cauc.   |  | Month DAY YEAR<br>May 11 1900   |  | 80 YRS.  |                           | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                     |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                           |  |   |  |
| Wash., D. C.  |  | USA   |  |   |  | Montgomery MD.   |                           |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                           | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Silver Spring   |  | Sylvan Manor Health Care Center   |  |   |  | Gov't.-Retired   |                           | U.S. Government  |   |  |
| 13a. STATE  |  |   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN         |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |   |  |   | Pr. George   |  | Forest Heights            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME   |  |                           |  |   |  |
| FIRST MIDDLE LAST<br>George Glorius   |  |   |  |   | FIRST MIDDLE LAST<br>Mary Schnopp  |  |                           |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT             |  |   |  |
| No  |  |   |  |   | 577-56-1955  |  | Elaine F. Campbell        |  |   |  |
|   |  |   |  |   | ADDRESS<br>1801 - 24th St., South<br>Arlington, Virginia   |  |                           |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |  |                           |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |  |                           |  |   |  |
| IMMEDIATE CAUSE (a) <i>renal failure</i>  |  |   |  |   |  |  |                           |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic cardio-</i>  |  |   |  |   |  |  |                           |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>vascular disease</i>  |  |   |  |   |  |  |                           |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |                           |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                           | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                           |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                           |  |   |  |
|   |  |   |  |   |  |  |                           |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/3</i> 19 <i>81</i> , to <i>4/3</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>4/3</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |   |  |   |  |  |                           |  |   |  |
| 22b. SIGNATURE<br><i>Barry N. Rosenbaum, M.D.</i>   |  |   |  |   | DEGREE   |  |                           | 22c. DATE SIGNED   |   |  |
|   |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                           | 4/3/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   | 22e. ADDRESS   |  |                           |  |   |  |
| Barry N. Rosenbaum, MD  |  |   |  |   | 3720 Farragut Ave<br>Kensington, Md 20781  |  |                           |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION             |  |   |  |
| Burial  |  |   | 4/8/81   |   | Ft. Lincoln Cemetery   |  | Brentwood Pr. Geo. Md.    |  |   |  |
| 24. FUNERAL DIRECTOR  |  |   |  |   | 25. DATE REC'D. BY REGISTRAR   |  | 25. REGISTRAR'S SIGNATURE |  |   |  |
| George P. Kalas Funeral Home  |  |   |  |   | 6160 Oxon Hill Rd.<br>Oxon Hill, Md.   |  | APR 9 1981                |  |   |  |

George P. Elias Funeral Home  
 6100 Oxon Hill Rd.  
 Oxon Hill, Md.  
 1/8/81  
 St. Lincoln Cemetery  
 Brentwood, Pr. Geo. Md.

George P. Elias Funeral Home

1/8/81

No  
 777-6-1952  
 Elaine L. Gilchrist  
 Arlington, Virginia  
 1901 - 24th St., South  
 Richmond  
 George  
 Elaine  
 Mary

Mayland Jr. George Forest Heights x 5715 Jackson Drive

Silver Spring  
 Sylvania Manor Health Care Center  
 Gov't.-Retired U.S. Government  
 Mary L. G.  
 1931  
 x  
 50

George  
 F.  
 Elaine, Sr.  
 1931-1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | REG. NO. 10868  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Audrey Jane Golden   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-7-81  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>March 8 <sup>th</sup> 1928   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Amer.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LOAH |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lithographer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Vitro Lab   |  |
| 13a. STATE<br>md.  |  |  |  | 13b. COUNTY<br>mont   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Earl Brown  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dora Kerr   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>Korean 268-24-5366   |  | 17. INFORMANT ADDRESS<br>2916 Lindell St.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CENTRAL NERVOUS SYSTEM METASTASIS</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA OF LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 months  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/24, 1981, to 4/7, 1981, that (I) (we) lost saw the deceased alive on 4/6, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Kirkland C. Brace  |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>4/7/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kirkland C. Brace   |  |  |  | 22e. ADDRESS<br>7600 Eastern Ave Takoma Park Md   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>April 9, 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington D. C.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi F.H. Silver Spring, Md. 20904   |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br>APR 13 1981  |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

3701

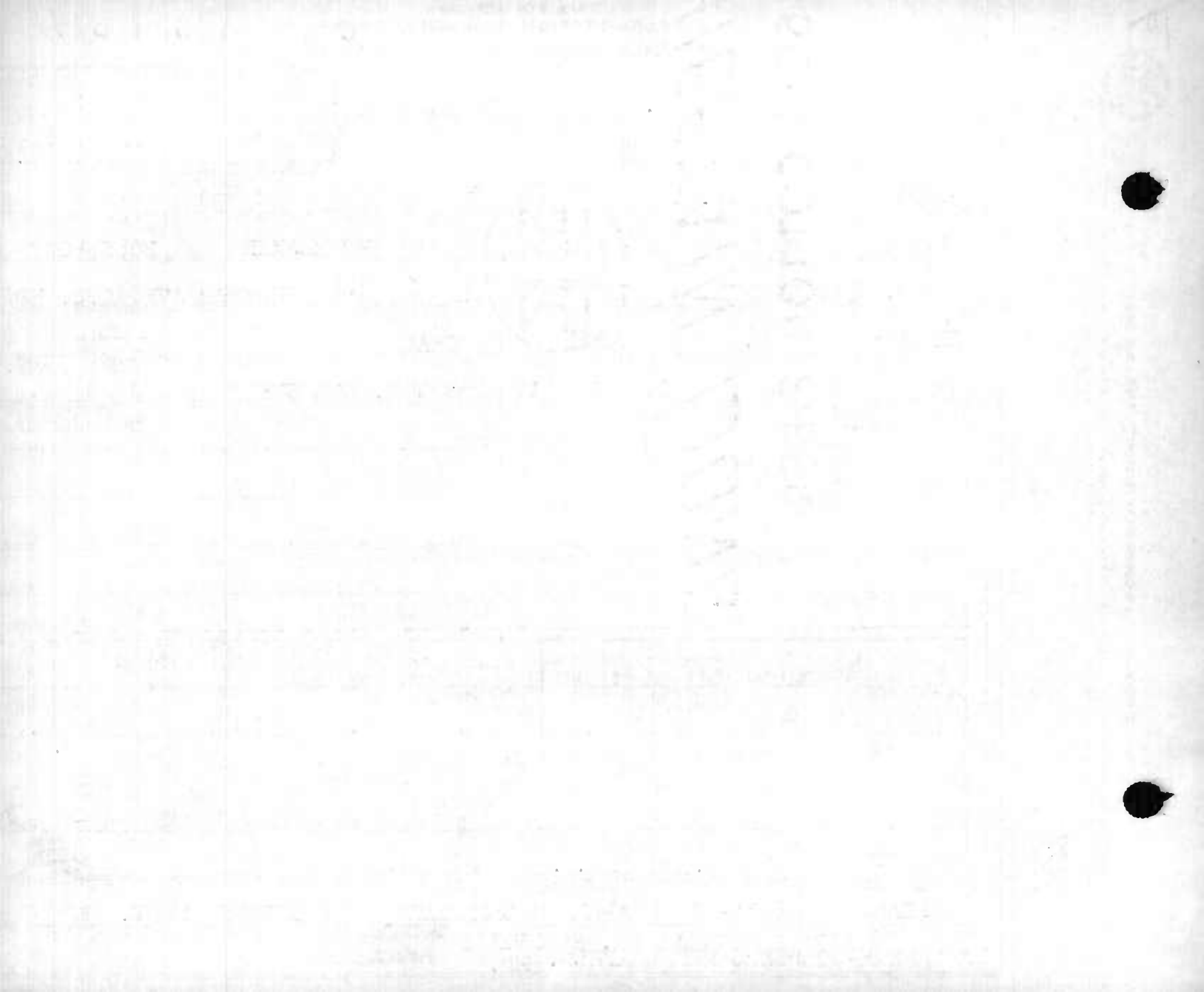




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                           |   |   |   |   |  |                        |  |   | REG. NO.   |  |
|---|---------------------------|---|---|---|---|--|------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Helen E. Goldstein   |                           |   |   |   |   |  |                        |  |   | 7a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>4 11 1981 |  |
| 3. SEX<br>Female  | 4. RACE<br>White          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 17 1919   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>61 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 11 1981                    | 7d. HOUR<br>11:45 P.M. |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>OHIO   |                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.              |                        |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |                           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOUSEWORK                   |   |  |  |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                           |   |   |   |   |  |                        |  |   |  |  |
| 13a. STATE<br>MD.   | 13b. COUNTY<br>MONTGOMERY | 13c. CITY OR TOWN<br>CHEVY CHASE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>6916 WESTERN AVE. C.C. MD  |   |  |                        |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM B. ESHOM  |                           |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GRACE LEWIS                                    |   |   |  |                        |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |                           |   | 16b. SOCIAL SECURITY NO.<br>NONE  |   | 17. INFORMANT<br>ADDRESS 6916 WESTERN AVE.<br>HARRY D. GOLDSTEIN CHEVY CHASE, MD.   |  |                        |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt injury to Trunk<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                           |   |   |   |   |  |                        |  |   |  |  |
| 19a. DATE OF OPERATION<br>-----   |                           |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>-----                                      |   |   |  |                        |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                           |   | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>11:04 A.M. 4 11 1981                              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger was ejected when auto slid on wet pavement |  |                        |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                           |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street                           |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>6 Plantation Ct., Rockville, Montgomery Co., Md.                                 |  |                        |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |                           |   |   |   |   |  |                        |  |   |  |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan   |                           |   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |   |   |  |                        |  | DATE SIGNED<br>4-12-81  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                           |   | ADDRESS<br>111 Penn Street  |   |   |  |                        |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |                           |   | 23b. DATE<br>4-15-81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKLAWN CEMETERY   |  |                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROCKVILLE MONT. MD |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>DANZANSKY-GOLDBERG MEM CHAPELS. MD.   |                           |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981  |  |                        | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                        |   |  |  |

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

10870

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |   |  |  |  |  |
|--|--|---|--|--|---|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Elsie Gore</b>   |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br><b>April 22, 1981</b>       |  |   | 2b HOUR<br><b>8:00AM</b>  |  |  |  |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 25, 1903</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>   |  | 7b HOUR<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>home</b>      |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md</b>                |  |   | 13b COUNTY<br><b>Mont</b>                                      |  | 13c CITY OR TOWN<br><b>Silver Spring</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>1515 Ednor Road</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Krams</b>   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie ?</b> |  |   |   |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES)<br><b>no</b> |  |   | 16b SOCIAL SECURITY NO<br><b>216 10 5921</b>                   |  | 17 INFORMANT ADDRESS<br><b>Carla Green 2800 Beechmont Lane, Silver Spring, Md</b> |   |  |  |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Right Hemisphere Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Atherosclerotic Cerebro Cardio Vascular Dis.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)<br><b>old left hemisphere Cerebro Vascular Accident</b> |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b><br><b>9 days</b><br><b>YEARS</b> |   |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>April 12, 1981</b> to <b>April 22, 1981</b> , that (I) (we) last saw the deceased alive on <b>April 22, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <b>81</b> the body after death.   |  |   |  |   |  |
| 22b SIGNATURE<br><b>Cezar G. Lopez</b>  |  | DEGREE<br><b>MD</b>   |  | 22c DATE SIGNED<br><b>April 22, 1981</b>                                      |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e ADDRESS   |  |   |  |

|   |  |                                  |  |  |  |   |  |
|---|--|----------------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>XXXXXX</b> |  | 23b DATE<br><b>Apr. 23, 1981</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Md</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Donaldson F. Home</b>   |  |                                  |  | ADDRESS<br><b>Laurel, Md.</b>                                  |  | 25 DATE REC'D BY REGISTRAR<br><b>APR 28 1981</b>                    |  |
|   |  |                                  |  | 26 REGISTRAR'S SIGNATURE                                       |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



THE CASE

150

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

10871

FOR  
1- STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Hubert</b>  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 20. DATE KNOWN<br>OF DEATH ESTI-<br>MATED <input checked="" type="checkbox"/> <b>4</b> MONTH <b>11</b> DAY <b>19</b> YEAR <b>81</b> |  | 20. HOUR <b>P</b>   |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>8</b> YEAR <b>23</b>  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>58</b> YRS.   |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                      |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) <b>Retired</b>                 |  | 12b. KIND OF BUSINESS<br>INDUSTRY <b>Institutes of Health</b>   |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>11601 Nairn Rd.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Hubert</b> MIDDLE <b>L.</b> LAST <b>Gore, Sr.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elsie</b> MIDDLE <b>Krams</b>  |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>yes</b>   |  | 16b. SOCIAL SECURITY NO. <b>WW 11 577-26-7126</b>   |  | 17. INFORMANT (wife) ADDRESS <b>Evelyn K. Gore-(same as 13e)</b>  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Inf.</b><br><b>4291</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Chronic Myocardial Inf.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>None</b>   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL<br>SIGNATURE <b>John S. Rogers</b>  |  | TITLE (SPECIFY) <b>DME</b>  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>April 11, 1981</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>John S. Rogers, DME</b>  |  | ADDRESS <b>Silver Spring, Maryland</b>  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>  |  | 23b. DATE <b>4-14-1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Alexandria</b> COUNTY <b>Alex.</b> STATE <b>Va.</b>            |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b>  |  | ADDRESS <b>8434 Ga. Ave., S.S. Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 16 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>James E. McElreen</b>   |  |   |  |   |  |

BP

| FUND |   | ACCOUNT |   | OBJECT CLASS |   | DETAILS |   | AMOUNT |    |
|------|---|---------|---|--------------|---|---------|---|--------|----|
| 1    | 2 | 3       | 4 | 5            | 6 | 7       | 8 | 9      | 10 |
|      |   |         |   |              |   |         |   |        |    |
|      |   |         |   |              |   |         |   |        |    |
|      |   |         |   |              |   |         |   |        |    |

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |  |  | 8 1 1 0 8 7 2  |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |  |  |   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>FLORENCE I DA GREEN</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 4 1981</b> |   |  | 2b. HOUR<br><b>8:50A M</b>   |  |  |  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 27, 1917</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASSACHUSETTS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY</b> MD.                        |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)<br><b>PURCHASING AGENT</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N.I.H.</b>                                   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MARYLAND MONTGOMERY ROCKVILLE</b>  |  |   |  |  |  |   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>4421 FAROE PLACE</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM WEINER</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE FEIN</b>  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>010-09-6499</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>RUTH BETTY HUSTON, 4421 FAROE PLACE, ROCKVILLE, MARYLAND</b> |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes Mellitus</b>   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)              |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>March 17, 1981</b> , to <b>April 4, 1981</b> , that (1) (we) last saw the deceased alive on <b>April 3, 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Michael A. Dodajda</b>   |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>April 4, 1981</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael A. Dodajda</b>  |  |   |  | 22e. ADDRESS<br><b>13975 Connecticut Ave Silver Spring, MD</b>   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  |   |  | 23b. DATE<br><b>4/6/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND, PR. GEORGES, MD.</b>      |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b><br><b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 7 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |  |  |





STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STUDY - 191

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 0 8 7 3  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>Loretta W. GREEN  |  | MONTH DAY YEAR<br>April 20 81   |  |
| 3. SEX<br>Female   |  | 2b. HOUR<br>10:30 AM  |  |
| 4. RACE<br>caucasian   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 26 98   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Wash. D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>home   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>Rockville  |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>13401 Tangier Place  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edwin A. Sullivan  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Christine A. Scheaffer   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-28-1922  |  |
| 17. INFORMANT<br>ADDRESS<br>Marianne W. Hollis same as 13e   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Diffuse Histiocytic Lymphoma</i><br>2000<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 mo  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>Lymphoma of small bowel; Surgically treated int. obstruction 2° lymphoma, COPD.</i>   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                              |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11.1980</u> , 19 <u>81</u> , to <u>4.20</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4.20</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |   |  |
| 22b. SIGNATURE<br><i>Donald E. Dillon</i>  |  | 22c. DATE SIGNED<br>4.21.81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD E DILLON, M.D.   |  | 22e. ADDRESS<br>18111 Prince Philip Dr..OLNEY, Md.20832   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4/24/81  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN<br>Silver Spring, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1981  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Lifroy McCreedy</i>   |  |   |  |



Female

85

Wash. D.C.

USA

x

Montgomery

Olinx

Montgomery General Hospital

Montgomery

none

Maryland Montgomery Rockville

Y

1960 Transfer from

Edwin

William

Christine

A.

Schaeffer

no

578-58-1925

Marianne W. Hollis born in 1900

Burial 4/24/61 Date of Heaven Cemetery Silver Spring, Maryland  
 1321 Rockville Pike Rockville, Maryland  
 Green Leaf Funeral Home, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|---|--|--|
| 1- FOR STATE REGISTRAR   |  |  | REG. NO. 81 10874  |  |  |  |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |   | 2b. HOUR   |  |
| Rose Blanca HAVER  |  |  | April 29 1981  |  |  |  | 5:20P M                                       |  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | 7 IF UNDER 1 YEAR  |  |
| Female   |  | Caucasian  |  | May 17 1906  |  | 74   |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |
| Puerto Rico  |  | USA  |  |  |  | Montgomery MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda   |  | National Naval Medical Center  |  |  |  | Housewife  |   |  |  |
| 13a. STATE   |  |  |  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS                           |  |  |
| Delaware   |  |  |  |  | New Castle   |  | 1610 Ogletown Road                            |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |  |
| Alberto Gandia   |  |  |  |  | Juana Ygenez   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.                                 |  | 17 INFORMANT ADDRESS                          |  |  |
| No   |  |  |  |  | 222-26-8786  |  | CA Albert L. Kotzebue P.O. Box 983 Pilot Hill |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) Acute leukemia   |  |  |  |  |  |  |   |  |  |
| 2080 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                       |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |   |  |  |
|  |  |  | P.M. 19  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |
|  |  |  |  |  |  |  |   |  |  |
| 22a. I certify that I (this hospital) attended the deceased from 110 PM 19 Apr. 19 81 to 520 PM 29 Apr 19 81, that I (we) last saw the deceased alive on 29 Apr. 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death. |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| Carl Hume MD   |  |  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | Apr. 30, 1981  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e. ADDRESS   |   |  |  |
| Carl H. Hume, M.D.   |  |  |  |  |  | National Naval Medical Center, Bethesda, Md  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE       |  |  |
| Burial   |  |  | 5/4/81   |  | Arlington National                                       |  | Arlington, Arlington Va.                      |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | 25. STATE REG. D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE |  |   |  |  |
| Falls Church Funeral Home  |  |  |  |  | Falls Church, Va.  |  |   |  |  |

MEDICAL CERTIFICATION

29

BP

MINI  
20/02

Handwritten notes and diagrams on lined paper, including a large 'X' and various illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the permit after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles R. Hamm   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 28 81                                      |   | 2b. HOUR<br>1730 M   |
| 3. SEX<br>Male   | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 13 1925  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Massachusetts   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engr. Dept. of Agr. | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Derwood  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>17708 Caddy Drive   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence L. Hamm   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marion Saulpaugh   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 018-09-9704   | 17. INFORMANT<br>ADDRESS<br>Phyllis M. Hamm (same as 13e)                               |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>And. metastatic carcinoma R</u><br><u>adenocarcinoma metastatic to lungs.</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>metastatic carcinoma</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5-10 m. 6 months. |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>none</u>  |   |   |   |   |  |
| 19a. DATE OF OPERATION<br>—  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> 19 <u>80</u> , to <u>April 28</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>April 28</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Ruben P. Cosca</u>  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   | 22c. DATE SIGNED<br><u>Apr/29/81</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>RUBEN P. COSCA, M.D.</u>   |   | 22e. ADDRESS<br><u>17529 REDLAND ROAD<br/>DERWOOD, MD, 20855</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>May 4, 1981  | 23c. NAME OF CEMETERY OR CREMATORY<br>Waterside Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN<br>Marblehead   | COUNTY STATE<br>Massachusetts  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey   |   | ADDRESS<br>300 W. Montgomery Ave., Rockville, Maryland  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 7 1981   | 25b. REGISTRAR'S SIGNATURE<br><u>P. J. Kelly</u>   |



*[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]*



FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                        |   |  |   |  |   |  |                                   |
|--|------------------------|---|--|---|--|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KENNETH WILLIAM HANKS</b>  |                        |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>4 18 19 81</b> |   |  | 2b. HOUR<br><b>2:21 AM</b>  |  |                                   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>CAUC</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 07 61</b>   | 6. AGE (LAST BIRTHDAY)<br><b>19</b>  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>XXXX</b>  | IF UNDER 24 HRS.<br>HOURS MIN<br><b>XXXX</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>4 18 19 81</b>                                 |  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                   |  |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>  |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SWADY GRAVE ADVOCIST</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electronic Tec.</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>MD</b>  |                        | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>DERWOOD</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kenneth P. Hanks</b>  |                        |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Staaden</b>   |  |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>XXX no</b>   |                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219 06 7587</b>   |  | 17. INFORMANT (father) ADDRESS<br><b>Mr. Kenneth P. Hanks 3130 Wisc. Ave. Wash. D.C.</b>  |  |   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE TRAUMA</b><br>8150<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b>          |                        |   |  |   |  |   |  |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).  |                        |   |  |   |  |   |  |                                   |
| 19a. DATE OF OPERATION<br>—  |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>—  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>100 4 18 19 81 HIT TREE</b>  |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 4 18 19 81</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>HIT TREE</b>  |  |   |  |                                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>STREET</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>18306 Laytonville Rd. Gaithersburg, Md. MD</b>  |  |   |  |                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                        |   |  |   |  |   |  |                                   |
| ACTUAL SIGNATURE<br><b>Francis C. Mayle</b>  |                        | TITLE (SPECIFY)<br><b>Dept</b>  |  | M.D.<br><b>Dept</b>   |  | DATE SIGNED<br><b>4/18/81</b>   |  |                                   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>FRANCIS C MAYLE</b>  |                        | ADDRESS<br><b>8100 Wisconsin Ave NW</b>   |  | CITY OR TOWN<br><b>DEPT</b>   |  | STATE<br><b>MD</b>  |  |                                   |
| 23a. <del>DATE OF</del> CREMATION-REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |                        | 23b. DATE<br><b>Apr. 21, 1981</b>   |  | 23c. NAME<br><b>XXXXXX</b> CREMATORY<br><b>Lee Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wash. D.C.</b>                                 |  |                                   |
| 24. FUNERAL DIRECTOR<br><b>W.W. Taltavull</b><br><b>4748 Wisc. Ave. N.W. Wash, D.C.</b>  |                        |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>APR 22 1981</b>   |  |   |  |                                   |



1940

Electronic Sec.

Kennedy  
 Adm. Sec.  
 (former)  
 2100 Ave. N.  
 Wash., D.C.

Removal  
 Apr. 21, 1941  
 Wash., D.C.  
 Wash., D.C.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

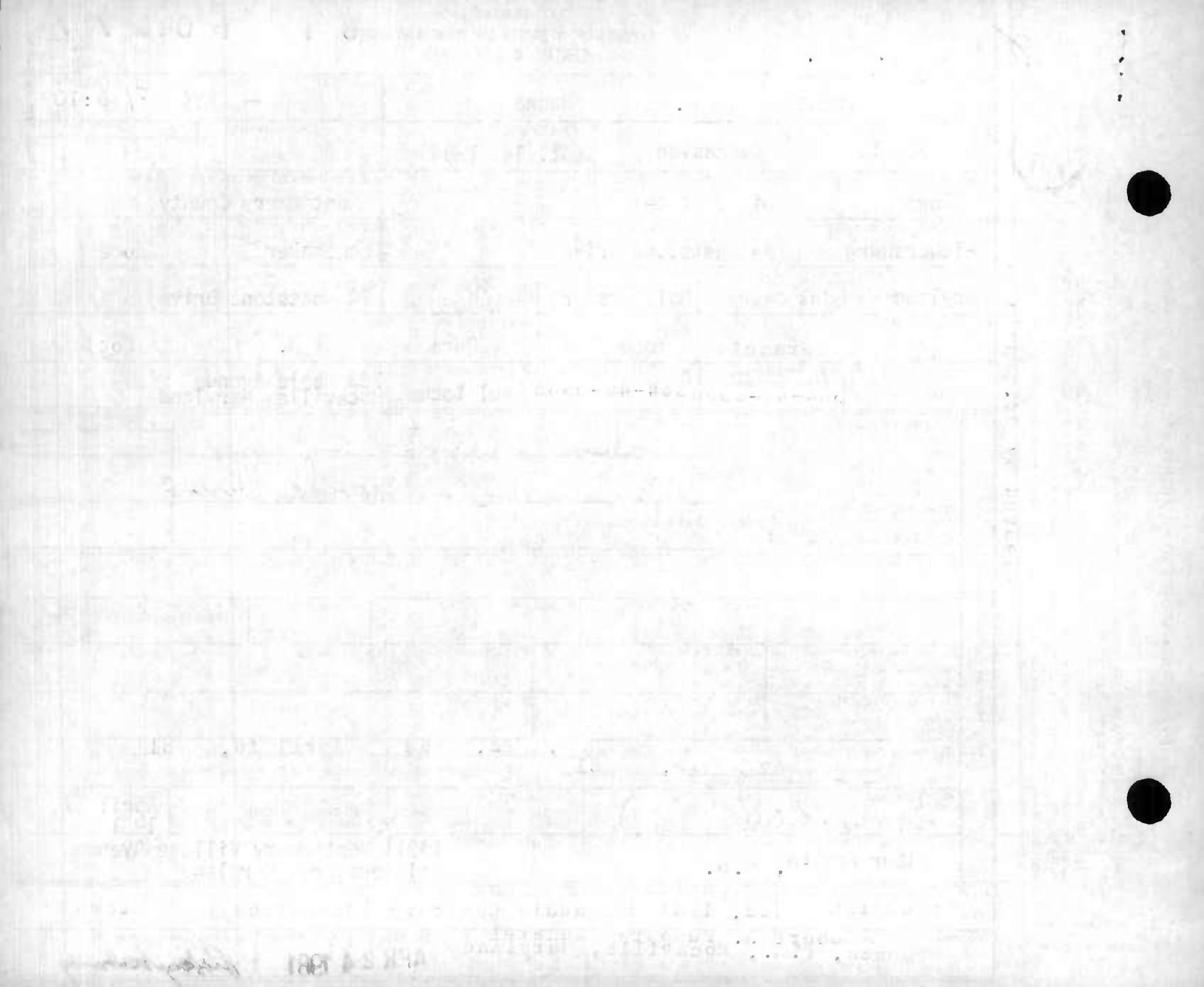
## CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
|--|--|---|--|---|--|---|--|--|--|---------------------------------------|--|--|--|----------------------------------|--|-------------------|--|--|--|--------------|--|--|--|
| 1. FOR<br>REGISTERAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Irene  |  | MIDDLE<br>C.  |  | LAST<br>Hanna  |  | 2a. DATE OF DEATH<br>MONTH<br>4       |  | DAY<br>16  |  | YEAR<br>81                       |  | 2b. HOUR<br>6:10P |  |  |  |              |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH<br>Sept.  |  | DAY<br>14   |  | YEAR<br>1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS<br>HOURS<br>MIN. |  |                   |  |  |  |              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iowa  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                                  |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>#4 Whetstone Drive |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Gaithersburg   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>#4 Whetstone Drive  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 14. FATHER'S NAME<br>James   |  |   |  | MIDDLE<br>Francis   |  |   |  | LAST<br>Yocum  |  |                                       |  | 15. MOTHER'S MAIDEN NAME<br>Cora   |  |                                  |  | MIDDLE<br>M.      |  |  |  | LAST<br>Boyd |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATE)<br>384-46-8566   |  |   |  | 17. INFORMANT<br>Paul Yocum, 723 Maple Avenue, Rockville, Maryland                   |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i>   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |                   |  |  |  |              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 22, 1968</u> , to <u>April 16, 1981</u> , that (I) (we) lost saw the deceased alive on <u>April 16, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 22b. SIGNATURE<br><i>Tibor Frekko</i> DEGREE   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Tibor Frekko, M.D.  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 22e. ADDRESS<br>19211 Montgomery Village Avenue<br>Gaithersburg, Maryland  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>April 22, 1981   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glendale Cemetery                              |  |                                       |  | 23d. LOCATION<br>Des Moines COUNTY Iowa STATE  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Humphrey<br>Homes, P.A., Rockville, Maryland   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>APR 24 1981   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Humphrey</i>  |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                  |  |                   |  |  |  |              |  |  |  |

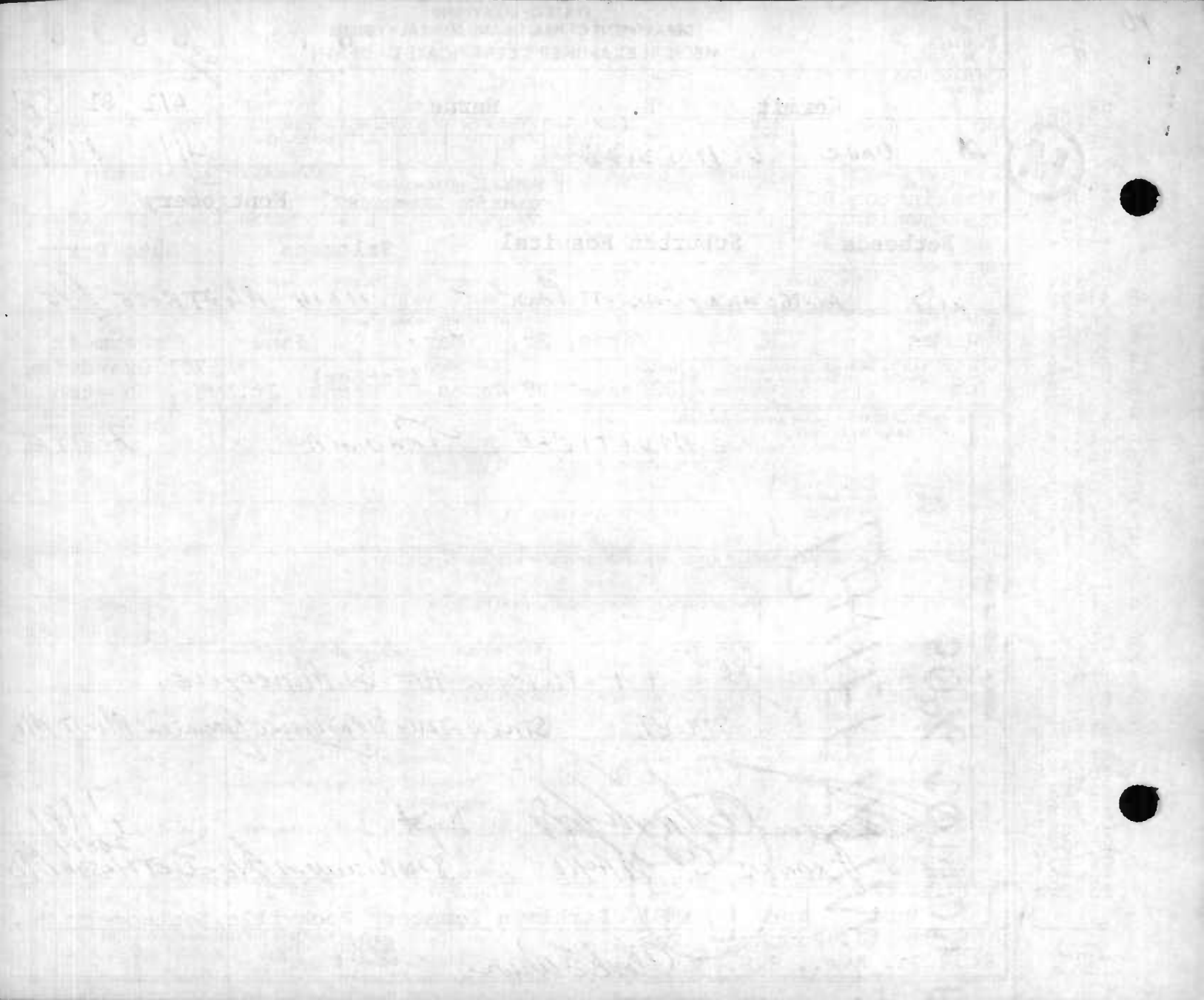
Cleared by Dr. Mayle

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                     |  |  |  |  |  |  |  |  | REG. NO. 10878       |  |
|---|---------------------|--|--|--|--|--|--|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kermit R. J. Harns</b>   |                     |  |  |  |  | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>4</b> DAY <b>1</b> YEAR <b>81</b> |  | 21. HOUR <b>8:45</b>   |  | 22. HOUR <b>8:45</b> |  |
| 3. SEX <b>M</b>   | 4. RACE <b>CAUC</b> | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>19</b> YEAR <b>52</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>28</b> | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 21. DATE PRONOUNCED DEAD<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>81</b>                                 |  | 22. HOUR <b>8:45</b>   |  | 23. HOUR <b>8:45</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, DC</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. <del>XXXXXX</del> NEVER MARRIED <input checked="" type="checkbox"/> <del>XXXXXX</del> <del>XXXXXX</del> <del>XXXXXX</del> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Parts</b>   |  |                      |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                     |  |  |  |  | 13a. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO           |  |  |  |                      |  |
| 13a. STATE <b>MD</b>  |                     | 13b. CITY OR TOWN <b>MONTGOMERY</b>  |  | 13c. STREET ADDRESS <b>GARRETT PARK</b>  |  | 13d. STREET ADDRESS <b>11014 MONTROSE AVE</b>  |  |  |  |                      |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>K.</b> LAST <b>Harns, Jr.</b>   |                     |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Jane</b> LAST <b>McDermott</b>                 |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>no</b>   |                     | 16b. SOCIAL SECURITY NO.<br><b>220-60-0409</b>   |  | 17. INFORMANT (father)<br><b>James K. Harns, Jr.</b>   |  | ADDRESS <b>1701 Grandview Ave., Wheaton, Md</b>  |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE TRAUMA</b><br>8129<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b>   |                     |  |  |  |  |  |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                     |  |  |  |  |  |  |  |  |                      |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |                     |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>—</b>  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     |  |  | 21b. TIME OF INJURY<br>HOUR <b>7:00</b> A.M. MONTH <b>4</b> DAY <b>1</b> YEAR <b>81</b>                                      |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>TRUCK HIT BY MOTORCYCLE.</b>   |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |                     |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>STREET</b>   |  |  |  | 21f. LOCATION<br>STREET <b>STILLWATER</b> CITY OR TOWN <b>SPRINGGROVE</b> COUNTY <b>KENSINGTON</b> STATE <b>MD</b> |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |  |  |  |  |  |  |  |  |                      |  |
| ACTUAL SIGNATURE <b>Francis C. Mayke</b>  |                     |  |  | TITLE (SPECIFY) <b>DEPT</b>  |  |  |  | DATE SIGNED <b>4/1/81</b>  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>FRANCIS C MAYKE</b>  |                     |  |  | ADDRESS <b>820 WISCONSIN AVE BETHESDA MD</b>   |  |  |  | MEDICAL EXAMINER   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                     |  |  | 23b. DATE<br><b>Apr. 4, 1981</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>   |  |                      |  |
| 23d. LOCATION<br>CITY OR TOWN <b>Rockville</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b>  |                     |  |  | 24. FUNERAL DIRECTOR<br>NAME <b>Warner E. Pumphrey, Inc.</b> ADDRESS <b>8434 Ga. Ave., S.S. Md.</b>                          |  |  |  | 25a. DATE RECD. BY REGISTRAR <b>APR 7 1981</b>   |  |                      |  |
| 25b. REGISTRAR'S SIGNATURE <b>notary</b>  |                     |  |  |  |  |  |  |  |  |                      |  |





## MEDICAL CERTIFICATION

DHMH-16 30M 2/80  
(VRA 15, 4)



1945



8th Air Force

1st Bombardment Group



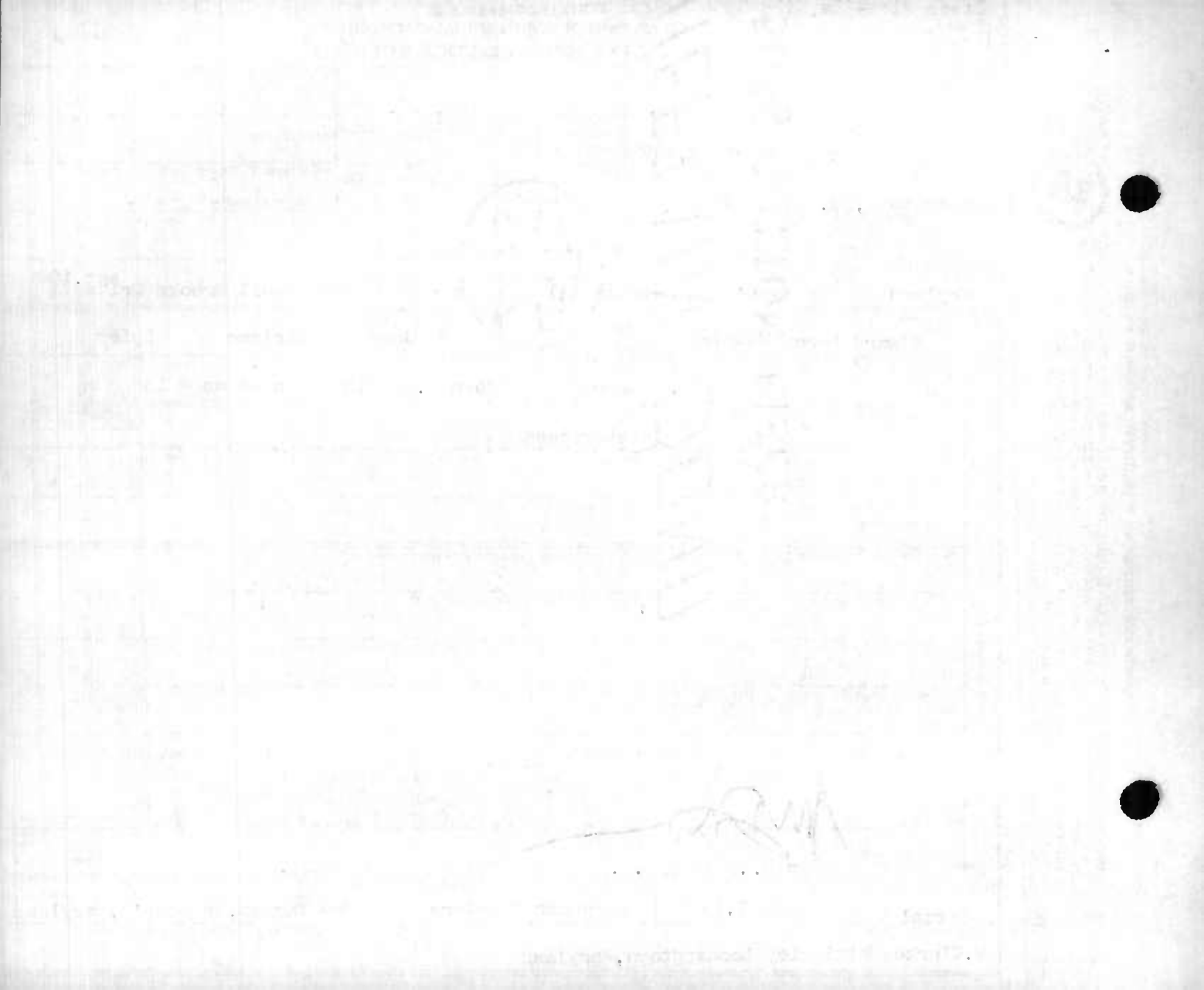
1945

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 9 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |   |   |                                |   |  |   |  | REG. NO. 10880  |  |
|--|------------------|---|---|---|--------------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EDWARD L. HAWKINS, JR.   |                  |   |   |   |                                |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br>4 29 19 81 |  |
| 3. SEX<br>male   | 4. RACE<br>negro | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 3, 1978  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>2 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>4 29 19 81  |  | 2d. HOUR<br>8:30  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Leonardtwn, Md.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hospital |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY<br>St Mary's  |   | 13c. CITY OR TOWN<br>Hyattsville  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5907 Knoll Brooke Drive Apt. 100                             |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edward Leroy Hawkins  |                  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Joan Darlene Lyles  |                                |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>none   |   | 17. INFORMANT<br>Joan L. Hawkins  |                                | ADDRESS<br>same as # 13   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Undetermined</u><br>7999<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                  |   |   |   |                                |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |   |   |                                |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |   |   |                                |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>  |                  |   |   |   |                                | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  | DATE SIGNED<br>4-29-81  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |                  |   |   | ADDRESS<br>111 Penn St.   |                                |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>May 1, 1981  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ebenezer Cemetery   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>New Market, St Mary's, Maryland                   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. Clarke Mattingley   |                  |   |   |   |                                | ADDRESS<br>Leonardtwn, Maryland   |  | 25. DATE REC'D. BY REGISTRAR<br>MAY 4 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>         |  |

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |   |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |  |  |  |  |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH N. HEMPSTONE</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4/20/81</b>   |  |  |  |  | 2b. HOUR<br><b>7:40 PM</b>  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 22 1992</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                         |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                               |  |   |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  |   | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Bethesda</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET ADDRESS<br><b>5212 Wilson Lane</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Theodore W Noyes</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Prentice</b>  |  |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-50-4571</b>   |  | 17. INFORMANT<br><b>Son</b>  |  | ADDRESS<br><b>Chevy Chase, Md.<br/>John W Thompson, Jr. 4605 Langdrum Lane</b>       |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4280 pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>acute renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>congestive heart failure</b>  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>72 hrs</b><br><b>10 days</b> |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 22 1956</b> to <b>22 APR 1981</b> , that (we) lost <b>no</b> the deceased alive on <b>22 APR 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  |   | DEGREE<br><b>no</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br><b>4/22/81</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph M. Weyman MD</b>   |  |   |  |   | 22e. ADDRESS<br><b>7801 Mt Airy Ave Bethesda, MD 20814</b>   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |  |   | 23b. DATE<br><b>4/27/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Virginia</b>                           |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons Inc</b><br><b>5120 Wisc. Ave., N.W. Wash., D.C.</b>   |  |   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 27 1981</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |   |  |  |  |  |

White

XX

U.S.A.

D.O.

Home

Home

SIS 1100 1100

1100 1100

Cherry Chase, N.Y.  
John V. Thompson, Jr.  
405 1100 1100

Theodore V. Hayes  
John V. Thompson, Jr.

405-1100-11

No

4/2/1901  
George Taylor's Home Inc.  
SIO Mac, N.Y. 1100, D.O.  
4/2/1901  
Washington National Cemetery  
Washington Virginia

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |         |  |        |  |                               |  |                                |                                   |                          |   |            |
|--|---------|--|--------|--|-------------------------------|--|--------------------------------|-----------------------------------|--------------------------|---|------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE | LAST   | 2a. DATE KNOWN OF DEATH       |  | 2b. DATE ESTI- MATED           | MONTH                             | DAY                      | YEAR  | 4. HOUR    |
| Ruth LeVerne Henderson   |         |  |        |  | 4/4 19 81                     |  |                                |                                   |                          |   | 4:05 P. M. |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |        | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   | IF UNDER 1 YR.<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN. |                                   | 2c. DATE PRONOUNCED DEAD |   | 4. HOUR    |
| Female   | White   | Mar. 15, 1911  |        | 70 YRS.  |                               |  |                                |                                   | 4/4 19 81                |   | 4:05 P. M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                |                                   |                          |   |            |
| Youngstown, Ohio   |         | U.S.A.   |        |  |                               | Montgomery County MD.  |                                |                                   |                          |   |            |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |                                | 12b. KIND OF BUSINESS OR INDUSTRY |                          |   |            |
| Silver Spring  |         | 9428 Curran Road   |        |  |                               | Housewife  |                                | Home                              |                          |   |            |
| 13a. STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET ADDRESS               |                          |   |            |
| Maryland   |         | Montgomery   |        | Silver Spring  |                               |  |                                | 9428 Curran Road                  |                          |   |            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         |  |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                               |  |                                |                                   |                          |   |            |
| George Osborne   |         |  |        | Lola Creed   |                               |  |                                |                                   |                          |   |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |        | 17. ADDRESS  |                               |  |                                |                                   |                          |   |            |
| No   |         | None   |        | 214-58-4682  |                               | 4995 Morningstar Dr. Dayton, Md. 21036<br>Timothy L. Henderson-son                   |                                |                                   |                          |   |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>chronic myocardial disease.</u><br>Years _____  |         |  |        |  |                               |  |                                |                                   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>None</u>   |         |  |        |  |                               |  |                                |                                   |                          |   |            |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |        |  |                               |  |                                |                                   |                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            |
| None   |         |  |        |  |                               |  |                                |                                   |                          |   |            |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><u>None</u>   |                               |  |                                |                                   |                          |   |            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                               |  |                                |                                   |                          |   |            |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |        |  |                               |  |                                |                                   |                          |   |            |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |        |  |                               | DATE SIGNED  |                                |                                   |                          |   |            |
|  |         | Deputy MEDICAL EXAMINER  |        |  |                               | 4/6/81   |                                |                                   |                          |   |            |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |        |  |                               |  |                                |                                   |                          |   |            |
| John S. Rogers, M.D.   |         | 1919 Seminary Road<br>Silver Spring, Montgomery, Md.   |        |  |                               |  |                                |                                   |                          |   |            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                                |                                   |                          |   |            |
| Cremation  |         | 4-5-81   |        | Lee's Crematory  |                               | Washington, D.C. 20002   |                                |                                   |                          |   |            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         | 25a. DATE REC'D. BY REGISTRAR  |        | 25b. REGISTRAR'S SIGNATURE   |                               |  |                                |                                   |                          |   |            |
| Lee Funeral Home 300-4th St. N.E. Wash. D.C.   |         | 20002  |        | APR 10 1981  |                               |  |                                |                                   |                          |   |            |

Youngstown, Ohio  
U.S.A.

Howe  
Housville

George (George)  
No  
214-8-145  
info. from  
U.S. - American, W. Union, No. 2134  
America, I. Henderson

Stamp  
11-11  
Lee's Commission  
APR 10 1961  
U.S. DEPT. OF JUSTICE  
U.S. DEPT. OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 927-3516.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |                          |   |   |  |   | 8 1 1 0 8 8 3                                |                     |      |          |  |
|---|--|--|--|--|--------------------------|---|---|--|---|--|---------------------|------|----------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | CERTIFICATE OF DEATH     |   |   |  |   |  |                     |      |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH        |   | MONTH                                     |  | DAY   |  | YEAR                |      | 2b. HOUR |  |
| Elizabeth Marie Henrich   |  |  |  |  | April                    |   | 18  |  | 81  |  | 12 30               |      | a.m.     |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)                               |   | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.                             |                     |      |          |  |
| F   |  | White  |  | 3 29 95  |                          | 86  |   | YRS.   |   | MONTHS                                       |                     | DAYS |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |   |  |                     |      |          |  |
| Germany   |  | American   |  |  |                          | Montgomery MD.  |   |  |   |  |                     |      |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |                     |      |          |  |
| TA Koma Park  |  | Washington Adv. Hospital   |  |  |                          | Housewife   |   |  |   |  |                     |      |          |  |
| 13a. STATE  |  |  |  |  | 13b. COUNTY              |   | 13c. CITY OR TOWN                         |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |      |          |  |
| Md.   |  |  |  |  | PG                       |   | Hyatts.                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2503 Amherst Road   |      |          |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME |   |   |  |   |  |                     |      |          |  |
| Henry Hulser  |  |  |  |  | Gertrude                 |   |   |  |   | Schweers                                     |                     |      |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT ADDRESS                     |  |   |  |                     |      |          |  |
| None  |  |  |  |  | 124 09 8870              |   | Gertrude Smith (Daughter) (Same as above) |  |   |  |                     |      |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:   |  |  |  |  |                          |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                     |      |          |  |
| IMMEDIATE CAUSE (a) Aspiration Pneumonia  |  |  |  |  |                          |   |   |  |   | 3 days.                                      |                     |      |          |  |
| DUE TO, OR AS A RESULT OF (b) stroke  |  |  |  |  |                          |   |   |  |   | 7 days.                                      |                     |      |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |                          |   |   |  |   |  |                     |      |          |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |                          |   |   |  |   |  |                     |      |          |  |
| Pulmonary Emphysema   |  |  |  |  |                          |   |   |  |   |  |                     |      |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                          | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |                     |      |          |  |
| NO  |  |  |  |  |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |                     |      |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |                          | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |   |  |   |  |                     |      |          |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | P.M. 19  |                          |   |   |  |   |  |                     |      |          |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |                          |   |   |  |   |  |                     |      |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | CITY OR TOWN COUNTY STATE  |                          |   |   |  |   |  |                     |      |          |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/13 19 81 to 4/18 19 81, that (I) (we) lost saw the deceased alive on 4/15 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |                          |   |   |  |   |  |                     |      |          |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |                          |   |   | 22c. DATE SIGNED   |   |  |                     |      |          |  |
| Norman A. Luban M.D.  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |                          |   |   | 4/18/81  |   |  |                     |      |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |                          |   |   |  |   |  |                     |      |          |  |
| Norman A. Luban   |  |  |  | 8200 Wisconsin Ave. Bethesda.  |                          |   |   |  |   |  |                     |      |          |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION   |   |  |   |  |                     |      |          |  |
| Burial  |  | 4/21/81  |  | Mt. St. Mary's Cemetery  |                          | Flushing Queens N.Y.  |   |  |   |  |                     |      |          |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |                          |   |   | 25b. REGISTRAR'S SIGNATURE                                     |   |  |                     |      |          |  |
| Hines/Rinaldi F.H.11800 N.H.Ave. S.S.Md.  |  |  |  | APR 22 1981  |                          |   |   |  |   |  |                     |      |          |  |

High-Altitude  
Step

Mountainous

18/10/18  
The Mountainous  
High-Altitude Step

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

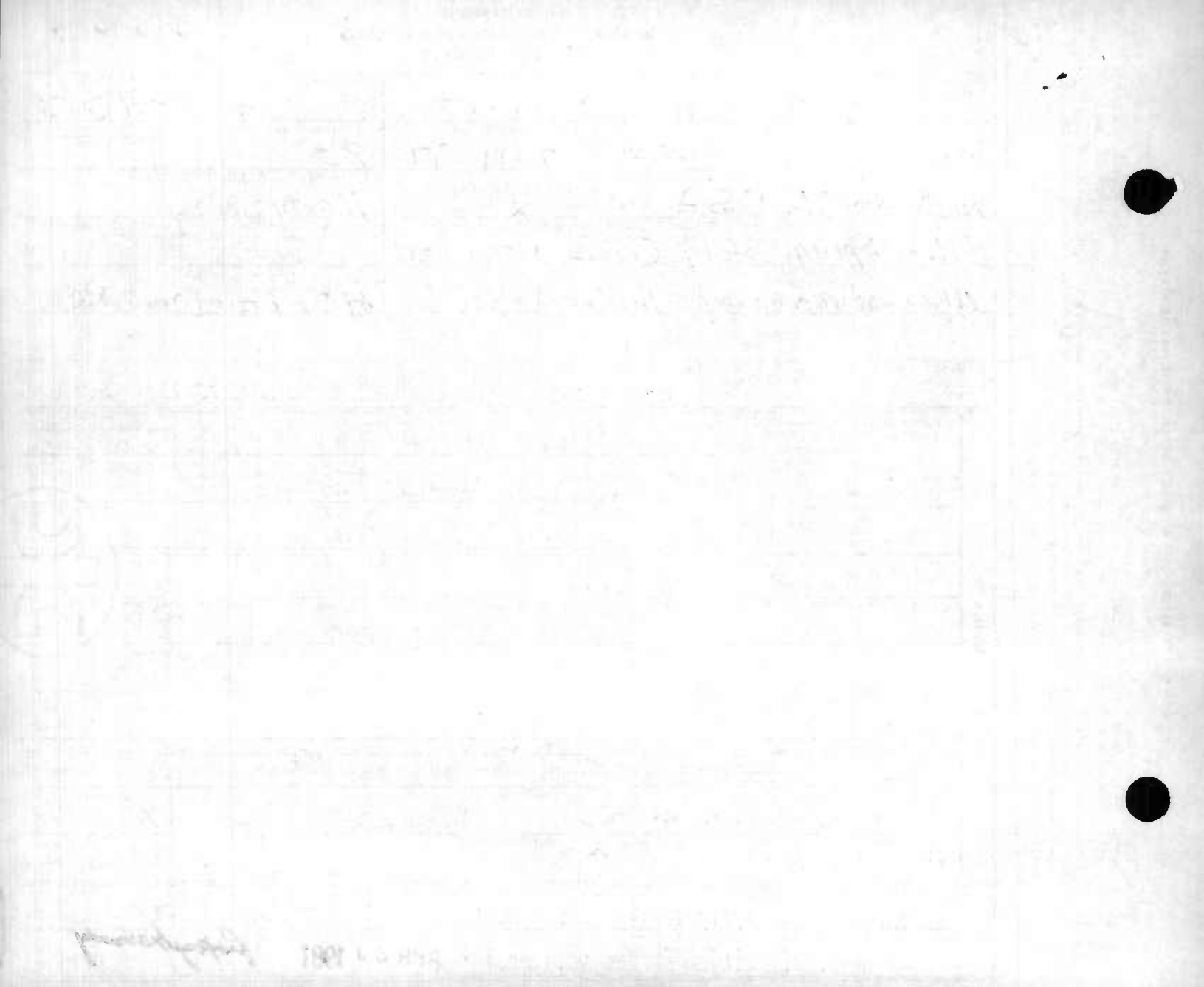
1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elsie M Herbert</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-18-81</b>                   |   | 2b. HOUR<br><b>530</b> PM  |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 11 97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Maryland</b> 13c. COUNTY <b>Montgomery</b> 13d. CITY OR TOWN <b>Silver Spring</b>   |  |   |   |   |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13f. STREET ADDRESS<br><b>3549 RAYMOOR ROAD<br/>SILVER SPRING, MD.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN BALL</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE T. BIRCH</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-10-5113</b>                          |   | 17. INFORMANT<br>ADDRESS<br><b>JOHN E. HERBERT SAME AS 13 SON</b>                    |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>Arteriosclerotic Cardiovascular Disease</b> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 minutes</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Renal Failure</b>  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1981</b> to <b>April 18, 1981</b> , that (we) lost saw the deceased alive on <b>April 18, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (we) (I) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Morton A. Aitschuler MD</b>  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4/18/81</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Morton A. Aitschuler MD</b>   |  |   |   | 22e. ADDRESS<br><b>1299 - Cameron Dr. Silver Spring, Md. 20902</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/21/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND PRY GEO MD.</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |
| 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901  |  |   |   |   |  |   |  |  |  |

MEDICAL CERTIFICATION

29

4100



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | April 29, 1981  |  | 2:50a M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female   |  | White  |  | April 15, 1884  |  | 97 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Cuba   |  | Cuba   |  | Montgomery County   |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Wheaton  |  | University Nursing Home  |  | Teacher   |  | Teaching  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  | Montgomery   |  | Wheaton   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| Aliao  |  | Concepcion   |  | None  |  | 042-60-2437   |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cervical arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  | 19. ADDRESS   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| Concepcion Castaneda   |  | 16100 New Hampshire Ave<br>Silver Spring, Md.  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1981</u> to <u>April 6, 1981</u> , that (I) <u>was</u> last saw the deceased alive on <u>April 6, 1981</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Edward J. Richards</u>  |  | 22c. DATE SIGNED<br><u>4-29-81</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |
| Edward J. Richards, M.D.   |  | 10301 Georgia Ave. Silver Spring, Md.  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial   |  | May 1, 1981  |  | Gate of Heaven Cem.   |  | Silver Spring, Mont. Co., Md.                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE OF DEATH   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Chambers Funeral Home  |  | Riverdale, Maryland  |  | MAY 6 1981  |  |   |  |



*Handwritten signature*  
MAY 8 1981





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |  |   |  |   |  |   |  |                                      |  |   |  |          |  |
|--|---------|--|--|---|--|---|--|---|--|--------------------------------------|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  |                                      |  | 2b. HOUR  |  |          |  |
| JAMES K HESS   |         |  |  |   |  |   |  | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 28 19 81       |  |                                      |  | 9P M  |  |          |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD             |  |   |  | 2d. HOUR |  |
| M  | CAUC    | 3 9 15   |  | 66 YRS.   |  |   |  |   |  | 4 28 19 81                           |  |   |  | 9P M     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | DIVORCED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  | MD.      |  |
| Pennsylvania   |         | U.S.A.   |  | WIDOWED   |  | <input checked="" type="checkbox"/>                                 |  |   |  | MONTGOMERY                           |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                                      |  |   |  |          |  |
| BETHESDA   |         | SUBURBAN HOSPITAL  |  | Civil Engr.   |  | U.S. Navy   |  |   |  |                                      |  |   |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                                      |  |   |  |          |  |
| FLA  |         |  |  | STATUTE DEPT  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 424 BLUE JAY LANE   |  |                                      |  |   |  |          |  |
| 14. FATHER'S NAME  |         | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE  |  | LAST                                 |  |   |  |          |  |
| James K.   |         |  |  | Hess  |  |   |  |   |  |                                      |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                                      |  |   |  |          |  |
| YES  |         | WWII   |  | 199-07-4579   |  | Mollie J. Hess (same as 13e)  |  |   |  |                                      |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |         |  |  |   |  |   |  |   |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |          |  |
| IMMEDIATE CAUSE (a) MULTIPLE TRAUMA  |         |  |  |   |  |   |  |   |  |                                      |  | 3 HRS   |  |          |  |
| 8269<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |  |   |  |   |  |                                      |  |   |  |          |  |
| (b) HEAD INJURIES  |         |  |  |   |  |   |  |   |  |                                      |  |   |  |          |  |
| (c)  |         |  |  |   |  |   |  |   |  |                                      |  |   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |   |  |                                      |  |   |  |          |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |                                      |  | 20. AUTOPSY?  |  |          |  |
|  |         |  |  |   |  |   |  |   |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                      |  |   |  |          |  |
|  |         |  |  | 5:45 P.M. 19  |  |   |  | FELL OFF BICYCLE  |  |                                      |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION   |  |                                      |  |   |  |          |  |
|  |         |  |  | STREET  |  |   |  | 16811 CAMBERFORD ST. DERWOOD MONT MD  |  |                                      |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |   |  |                                      |  |   |  |          |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |                                      |  |   |  |          |  |
| Francis C. Mayle   |         |  |  | Dpt   |  |   |  | 4/28/81   |  |                                      |  | 20014   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |  |   |  |   |  |                                      |  |   |  |          |  |
| FRANCIS C. MAYLE   |         |  |  | 8200 WISCONSIN AVE BETHESDA MD                                |  |   |  |   |  |                                      |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                      |  | 23d. LOCATION CITY OR TOWN  |  |          |  |
| Burial   |         |  |  | May 4, 1981   |  |   |  | Arlington Natl Cemetery   |  |                                      |  | Ft. Myer Arlington Virginia   |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |         |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |   |  |          |  |
| Robert A. Pumphrey Funeral Homes P/A   |         |  |  | MAY 7 1981  |  |   |  | Pumphrey  |  |                                      |  |   |  |          |  |
| 300 W. Montgomery Ave., Rockville, Md. 20850   |         |  |  |   |  |   |  |   |  |                                      |  |   |  |          |  |





Handwritten notes and stamps at the top of the page, including a date stamp "JUN 1964" and various illegible markings.

Main body of handwritten notes and stamps, including a large circular stamp in the lower left and various illegible markings throughout the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for post-mortem examination.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   |  | 8 1 1 0 8 8 7  |  |
|--|--|---|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | 2a. DATE OF DEATH   |  |  |  |
| FIRST Helen MIDDLE S. LAST Hewitt<br>Helen S. Hewitt   |  |   | MONTH DAY YEAR HOUR<br>APRIL 16 1981 12 PM                    |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>CAUCASIAN   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 11, 1907  |  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA MD   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL                              |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED-Retail Mgr.; Ladies Clothing |  |  |
| 13a. STATE<br>MD   |  |   | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Bethesda  |  |
| 14. FATHER'S NAME<br>FIRST James MIDDLE --- LAST Shea  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Annie MIDDLE --- LAST Kelly |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |  |   | 16b. SOCIAL SECURITY NO.<br>579-22-0387                       |  | 17. INFORMANT<br>ADDRESS<br>Edward G. Hermann, Same address as # 13. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arterio-sclerotic heart disease</u><br>7 days<br>5 years |  |   |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 76, to 4-16-19 81, that (I) (we) lost saw the deceased alive on 4-16-19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |  |
| 22b. SIGNATURE<br>MARVIN WADLER  |  |   |   | 22c. DATE SIGNED<br>4/16/81  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARVIN WADLER   |  |   |   | 22e. ADDRESS<br>8218 Wisconsin Av. Bethesda, Md.   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4/20/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cem.  |  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Silver Spring, Maryland   |  | 23e. COUNTY<br>Montgomery   |   | 23f. STATE<br>MD.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave., NW, Washington, D.C. 20016  |  |   |   | 25. DATE RECEIVED BY REGISTRAR<br>APR 16 1981  |  |  |



Dec. 11, 1908

0.30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR<br>1 - STATE<br>REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO.  |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CATHERINE A. HICKEY</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 23, 1981</b>  |  | 2b. HOUR<br><b>11:55 M</b>  |  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 22, 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Potomac</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>8548 Atwell Road</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael McCarthy</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Lyons</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215-58-9042</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Edward J. Hickey, Jr., Same as 13</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Staphylococcus Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>ORGANIC BRAIN SYNDROME</b>   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>4-20</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— — — 19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>—</b> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— — — — —</b>                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> 19 <b>81</b> to <b>4-23</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4-20</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Roland Imperial, MD</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4-23-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROLAND IMPERIAL</b>   |   | 22e. ADDRESS<br><b>4977 BATTERY LANE BETHESDA</b>   |  | 22f. SIGNATURE<br><b>MO. WOLK</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>April 27, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Maryland</b>  |   | 23e. DATE REC'D BY REGISTRAR<br><b>APR 30 1981</b>  |  | 23f. REGISTRAR'S SIGNATURE<br><b>Rickie K. K...</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPAKEY FUNERAL HOMES, P. A., Bethesda, Maryland</b>  |   |   |  |   |  |

Robert J. [unclear] 1111 [unclear] [unclear]  
 [unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

4-20 3-6 10 4-23 11

Original [unclear] [unclear]

[unclear] [unclear] [unclear]

BH

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |  |  |   |                                   |   |   |   |  |
|--|---|--|--|---|-----------------------------------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |  | 20. DATE OF DEATH  |   |                                   | 21. HOUR  |   |   |  |
| SUSIE ETTA HILL  |   |  | APRIL 3, 1981  |   |                                   | 4:54 P <sub>M</sub>   |   |   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |                                   | 7. IF UNDER 1 YEAR  |   |   |  |
| FEMALE   | NEGRO   | JULY 11, 1930  | 50 YRS   |   |                                   | MONTHS DAYS HOURS MIN.  |   |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 9. CITIZEN OF WHAT COUNTRY?   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH                                      |   |                                   |   |   |   |  |
| KENTUCKY   | U.S.A.  |  | MONTGOMERY COUNTY MD.  |   |                                   |   |   |   |  |
| 12. CITY OR TOWN OF DEATH  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                   |   | 15. KIND OF BUSINESS OR INDUSTRY          |   |  |
| BETHESDA   | THE CLINICAL CENTER, NIH  |  |  |   |                                   |   |   |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  | 17. CITY OR TOWN   |   |                                   | 18. INSIDE CITY LIMITS?   |   |   |  |
| MARYLAND   |   |  | Havre de Grace   |   |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |   |   |  |
| 19. FATHER'S NAME  |   |  | 20. MOTHER'S MAIDEN NAME   |   |                                   | 21. STREET ADDRESS  |   |   |  |
| SILAS  |   |  | NETTIE   |   |                                   | 420 S. OHIO ST., 21078  |   |   |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |  | 23. SOCIAL SECURITY NO.  |   |                                   | 24. INFORMANT ADDRESS   |   |   |  |
| YES  |   |  | 406-38-7446  |   |                                   | MR. ROBERT HILL (NOK) SAME AS ABOVE   |   |   |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  |  |   |                                   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART I. DEATH WAS CAUSED BY:   |   |  |  |   |                                   |   |   | Immediate   |  |
| IMMEDIATE CAUSE (a) Cardiac Arrest   |   |  |  |   |                                   |   |   |   |  |
| 2028 DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |   |                                   |   |   | 2 days  |  |
| (b) Septicemia   |   |  |  |   |                                   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |  |  |   |                                   |   |   | 8 years   |  |
| (c) Lymphoma   |   |  |  |   |                                   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |   |                                   |   |   |   |  |
| 26. DATE OF OPERATION  |   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |                                   | 28. AUTOPSY?  |   | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |
|  |   |  |  |   |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   |                                   | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |   |   |  |
|  |   |  |  |   |                                   |   |   |   |  |
| 33. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |                                   | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |
|  |   |  |  |   |                                   |   |   |   |  |
| 36. I certify that (I) (this hospital) attended the deceased from FEBRUARY 6, 1981, to APRIL 3, 1981, that (I) (we) last saw the deceased alive on APRIL 3, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |   |                                   |   |   |   |  |
| 37. SIGNATURE  |   |  | DEGREE   |   |                                   | 38. DATE SIGNED   |   |   |  |
| James L. Mulshine MD   |   |  |  |   |                                   | 4/4/81  |   |   |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |  | 40. ADDRESS  |   |                                   |   |   |   |  |
| JAMES L. MULSHINE  |   |  | NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MARYLAND 20205 |   |                                   |   |   |   |  |
| 41. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |  | 42. DATE   |   | 43. NAME OF CEMETERY OR CREMATORY |   | 44. LOCATION<br>CITY OR TOWN COUNTY STATE |   |  |
| Burial   |   |  | 4-8-81   |   | St. James Cemetery                |   | Havre de Grace Harford MD.                |   |  |
| 45. FUNERAL DIRECTOR<br>NAME   |   |  | 46. ADDRESS  |   |                                   | 47. DATE REC'D. BY REGISTRAR  |   | 48. REGISTRAR'S SIGNATURE   |  |
| ARNOLD W. BEARD  |   |  | 1178 Cecil Ave. N.E. MD.   |   |                                   | APR 10 1981   |   | L. J. [Signature]   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

PAID IN FULL





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35

27

35

56

1

1

9

1

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |  |   |  |                                    |  |  |  | 8   | 1 | 1                                 | 0 | 8                             | 9 | 0 |          |  |  |
|--|--|------------------------------|--|---|--|------------------------------------|--|--|--|---|---|-----------------------------------|---|-------------------------------|---|---|----------|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |                              |  |   |  |                                    |  |  |  | CERTIFICATE OF DEATH  |   |                                   |   |                               |   |   |          |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  |   |  |                                    |  |  |  | 7a. DATE OF DEATH MONTH DAY YEAR  |   |                                   |   |                               |   |   | 2b. HOUR |  |  |
| MICHAEL RYAN HOFFMAN   |  |                              |  |   |  |                                    |  |  |  | APRIL 10, 1981  |   |                                   |   |                               |   |   | 0355A M  |  |  |
| 3 SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS    |   | IF UNDER 24 HRS<br>HOURS MIN. |   |   |          |  |  |
| MALE   |  | CAUCASION                    |  | APRIL 6, 1981   |  |                                    |  | YRS. 4   |  |   |   |                                   |   |                               |   |   |          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |   |                                   |   |                               |   |   |          |  |  |
| MARYLAND   |  | U.S.A.                       |  |   |  |                                    |  | MONTGOMERY MD  |  |   |   |                                   |   |                               |   |   |          |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |                                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |                               |   |   |          |  |  |
| BETHESDA   |  |                              |  | NATIONAL NAVAL MED. CENTER  |  |                                    |  | NA   |  |   |   |                                   |   |                               |   |   |          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                              |  |   |  |                                    |  |  |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS               |   |                               |   |   |          |  |  |
| 13a. STATE 13b. COUNTY   |  |                              |  |   |  |                                    |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 1 WATCHWATER WAY                  |   |                               |   |   |          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |                              |  |   |  |                                    |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |                                   |   |                               |   |   |          |  |  |
| BARRY B. HOFFMAN   |  |                              |  |   |  |                                    |  |  |  | MAUREEN MURPHY  |   |                                   |   |                               |   |   |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |                              |  | 16b. SOCIAL SECURITY NO.  |  |                                    |  | 17. INFORMANT ADDRESS  |  |   |   |                                   |   |                               |   |   |          |  |  |
| NO   |  |                              |  | NA  |  |                                    |  | BARRY HOFFMAN, 1 WATCHWATER WAY  |  |   |   |                                   |   |                               |   |   |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>7469 IMMEDIATE CAUSE (a) CONGENITAL HEART ABNORMALITY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                              |  |   |  |                                    |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |                                   |   |                               |   |   |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |   |  |                                    |  |  |  |   |   |                                   |   |                               |   |   |          |  |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                   |   |                               |   |   |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |   |                                   |   |                               |   |   |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)   |  |                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |   |                                   |   |                               |   |   |          |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10 APR</u> , 19 <u>81</u> , to <u>10 APR</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased only on <u>10 APR</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (We) (did) (do not) view the body after death. |  |                              |  |   |  |                                    |  |  |  | 22c. DATE SIGNED<br>4/13/81   |   |                                   |   |                               |   |   |          |  |  |
| 22b. SIGNATURE<br>John H. Mading MD  |  |                              |  |   |  |                                    |  |  |  | 22e. ADDRESS<br>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD   |   |                                   |   |                               |   |   |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                              |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |                                   |   |                               |   |   |          |  |  |
| CREMATION  |  |                              |  | 4-13-81   |  | METROPOLITAN CREMATORY ALEXANDRIA  |  |  |  | VA.   |   |                                   |   |                               |   |   |          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |                              |  |   |  |                                    |  |  |  | 25. REGISTRAR'S SIGNATURE   |   |                                   |   |                               |   |   |          |  |  |
|  |  |                              |  |   |  |                                    |  |  |  |   |   |                                   |   |                               |   |   |          |  |  |

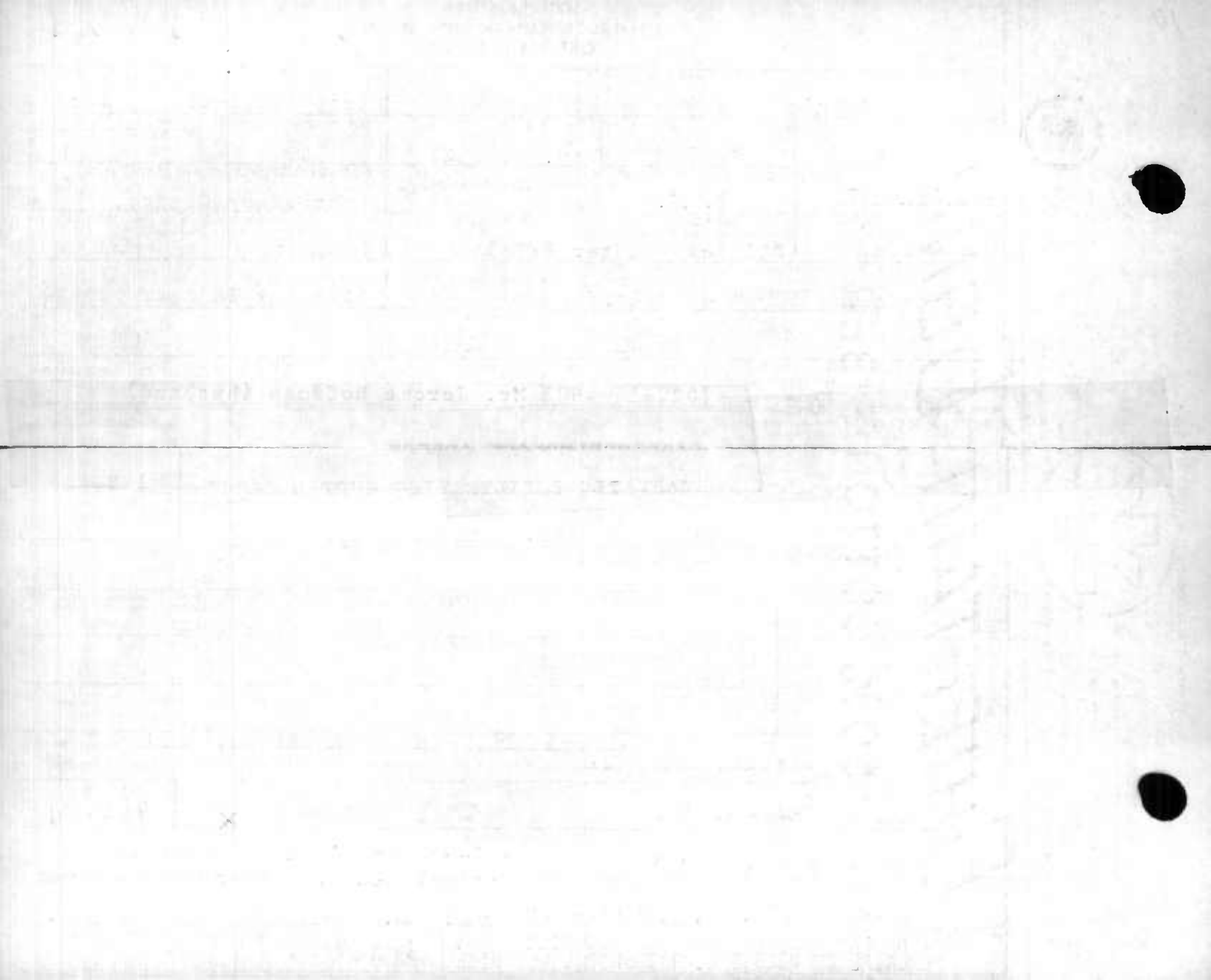
100% COTTON - ETC

DAVID B. WINTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |   |   |  |
|---|--|---|--|---|--|--|---|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |  |   |   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |   |  |
| REG. NO. 10891  |  |   |  |   |  |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Sylvia (NMN) Hoffman</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 22, 1981</b>            |  | 2b. HOUR<br><b>12:15 AM</b>   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 6, 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASSACHUSETTS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Clinical Center (NIH)</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |  |
| 13a. STATE<br><b>Bethesda</b>   |  |   | 13b. COUNTY<br><b>MONTGOMERY</b>   |   | 13c. CITY OR TOWN<br><b>Maryland</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br><b>6129 Durbin Road 20034</b>  |  |   |  |   |  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX KUSHNER</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VIVIAN BROWN</b> |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>020-16-4603</b>   |   | 17. INFORMANT ADDRESS<br><b>same as above</b>                        |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1749</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>METASTATIC INFILTRATING DUCTAL CARCI-</b><br>(c) <b>NOMA OF BREAST. THYROID GOITER</b>   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b>                                |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                            |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 18, 1981</b> to <b>April 22, 1981</b> , that I (we) lost<br>saw the deceased alive on <b>April 22, 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Martin Brower MD</b>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/22/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN BROWER MD</b>  |  |   | 22e. ADDRESS<br><b>National Institutes of Health<br/>Clinical Center Bethesda, Md, 20205</b> |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>APR. 24, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEM. GAR.</b>    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FALLS CHURCH Va.</b>                           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>DANZANSKY-GOLDBERG</b>   |  |   | ADDRESS<br><b>ROCKVILLE, MD.<br/>MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE</b>              |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 27 1981</b>   |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 0 8 9 2  |  |
|--|--|---|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| FIRST MARY MIDDLE A. LAST HOLDEN   |  |   |  | APRIL 17, 81   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 6 1882  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>99 YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 8. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |  | 10. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN Hospital |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  | 13a. STREET ADDRESS<br>3000 McComas Ave.   |  |
| 13b. STATE<br>Md.  |  | 13c. CITY OR TOWN<br>Kensington   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST Benjamin MIDDLE LAST Rowson   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary MIDDLE LAST Rlen   |  | 16. ADDRESS<br>Akron, Ohio   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>579-62-3338   |  | 17. INFORMANT<br>Eleanor Humphrey 526 N. Portage Path.,  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF (d) Arteriosclerosis<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e) ROYAL Failure |  |   |  | APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH<br>5 days<br>Yema<br>Yema   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (his hospital) attended the deceased from July 19 77 to 4/17/81, that (I) (we) lost saw the deceased alive on 4/17/81 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did not) view the body after death. |  | 22b. SIGNATURE<br>THOS G. WARD M.D.<br>22c. DATE SIGNED<br>4/18/81   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOS G. WARD  |  | 22b. ADDRESS<br>6116 Robinwood, Bethesda, Md 20834  |  | 22c. DATE SIGNED<br>4/18/81  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4/24/1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cemetery  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Virginia   |  | 24. FUNERAL DIRECTOR<br>NAME Joseph Gawler's Sons Inc<br>ADDRESS 5130 Wisc. Ave., N.W. Wash., D. C.   |  | 25. DATE REC'D. BY REGISTRAR<br>APR 21 1981  |  |
| 26. REGISTRAR'S SIGNATURE  |  | 27. REGISTRAR'S SIGNATURE   |  | 28. REGISTRAR'S SIGNATURE  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |   |   |   |   |  |
|---|--|---|---|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HALLIE H. HOLDER</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-24-1981</b>                              |   |  | 2b. HOUR<br><b>8.45 PM</b>  |   |   |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 02 16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>  |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                           |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAIL CARRIER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT.</b>  |   |  |
| 13a. STATE<br><b>VIRGINIA</b>   |  |   | 13b. COUNTY<br><b>AUGUSTA</b>   |   | 13c. CITY OR TOWN<br><b>STAUNTON</b>                             |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>628 ESSEX DRIVE</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ARTHUR H. HOLDER</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ESTHER SHOVER</b>             |   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>           |   | 17. INFORMANT<br><b>CAMILLA C. HOLDER</b>                        |   | ADDRESS<br><b>SAME AS 13</b>  |   | WIFE<br><b>WIFE</b>                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchogenic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pseudomonas Pneumonia</b>   |  |   |   |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>4/16/80</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Subclavian Obstruction</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)           |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)             |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10</b> , 19 <b>80</b> , to <b>4/24</b> , 19 <b>81</b> , that (1) (we) lost<br>saw the deceased on <b>4/24/80</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) (did not) (see) the body after death. |  |   |   |   |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Jay Weiner MD</b>  |  |   |   |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>4/25/81</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jay Weiner MD</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>SILVER SPRING MARY AND</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>4/27/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>THORN ROSE CEMETERY</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>STAUNTON AUGUSTA VA.</b>                       |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br>ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1981</b>                                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b>  |   |  |

BP





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |   |  |  |  |
|--|--|--|--|--|--|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Agnes C. Honey  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>April 22, 1981                   |  |  | 2b HOUR<br>5:01p M  |   |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 21, 1920   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS  |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Dakota   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Olney  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>co-owner         |   | 12b KIND OF BUSINESS OR INDUSTRY<br>greenhouse   |  |  |
| 13a STATE<br>Md  |  |  | 13b CITY OR TOWN<br>PG Beltsville                                      |  | 13c INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13d STREET ADDRESS<br>10900 Montgomery Road                         |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ivar Myhra  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Marie Roestead   |  |  |   |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b SOCIAL SECURITY NO.<br>514 18 9511                                 |  | 17 INFORMANT<br>ADDRESS<br>Woodrow Honey same as above   |   |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u><br>4300<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>ruptured Rt MCA aneurysm</u><br>(c) <u>with temporal lobe hematomas</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |   |  |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/22/81</u> to <u>4/22/81</u> , that (I) (we) lost saw the deceased alive on <u>4/22/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Gary W. London</u>  |  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4/22/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GARY W. LONDON  |  |  | 22e. ADDRESS<br>8200 WISCONSIN AVE                                     |  | BETHESDA, MD   |   |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>April 25, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Maryland |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Donaldson F. Home  |  |  | ADDRESS<br>Laurel, Md  |  | DATE RECEIVED BY REGISTRAR<br>APR 28 1981  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1950, 1951, 1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

FOR  
1- STATE  
REGISTRAR

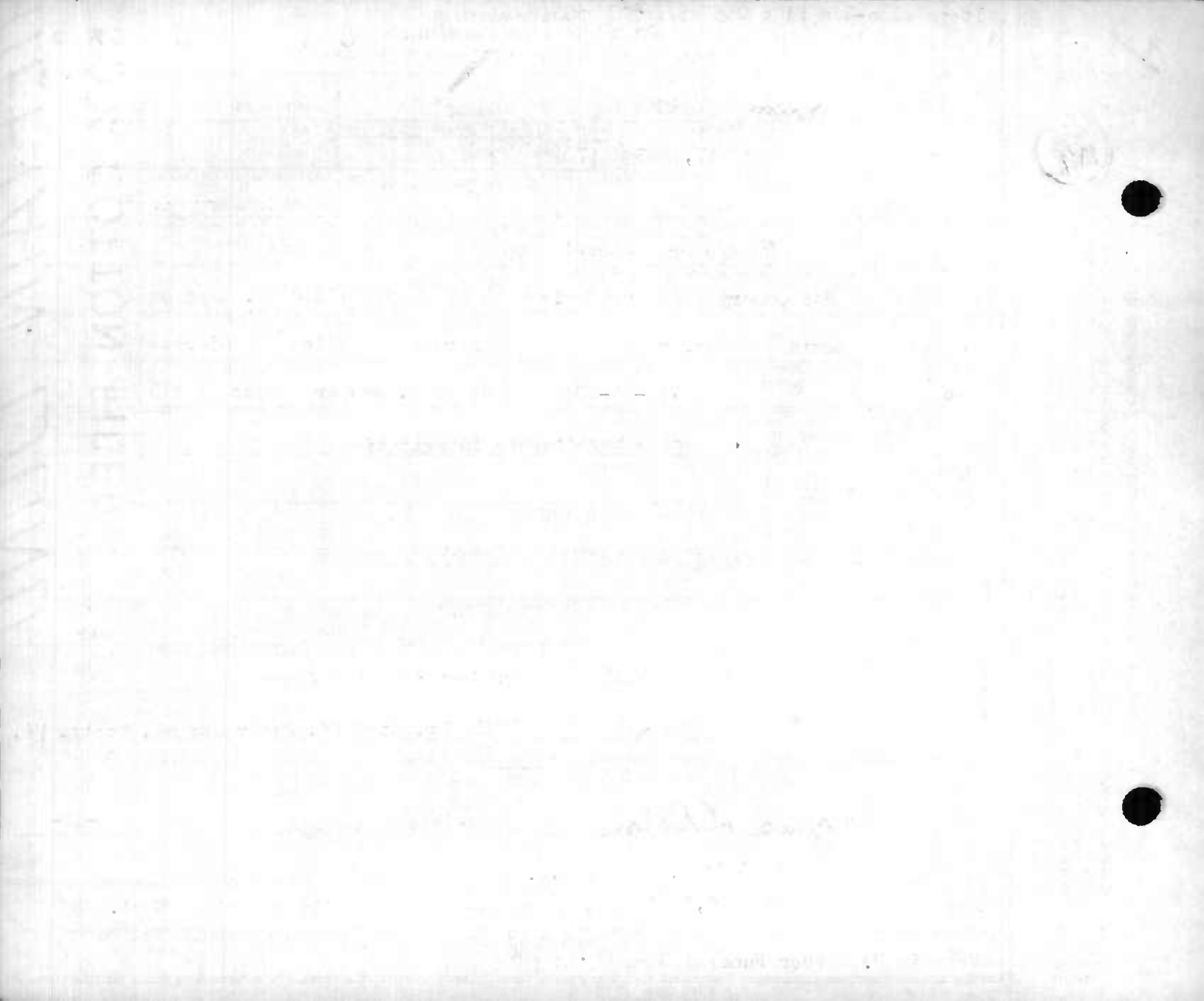
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                  |   |   |   |   |  |   |  |
|--|------------------|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DOUGLAS <del>James</del> JAMES Hooper   |                  |   | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>4 26 19 81          |   |   | 2b. HOUR<br>M<br>AM  |   |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 17, 1963  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>17 YRS.                       | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 26 19 81     | 2d. HOUR<br>9:47<br>A.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD |   |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>School   |  |
| 13a. STATE<br>Maryland   |                  |   | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Sandy Spring   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 13e. STREET ADDRESS<br>17214 Dr. Bird Road                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Lewis Hooper   |                  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Ellen Riches  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |                  | (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.<br>215-66-8942   |   | 17. INFORMANT ADDRESS<br>James L. Hooper Same as #13         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9501 IMMEDIATE CAUSE (a) Acute barbiturate intoxication<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 4/26/1981 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject ingested drugs |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>17214 Dr. Bird Rd. Sandy Spring, Montg. Md.        |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                   |   |   | DATE SIGNED<br>4-27-81                                       |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                  |   | ADDRESS<br>111 Penn Street  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |                  |   | 23b. DATE<br>April 29, 1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring Mont. Md                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Francis H. Barber Funeral Home   |                  |   | ADDRESS<br>Laytonsville Md. 20760                                   |   | 25a. DATE RECEIVED BY REGISTRAR<br>MAY 1 1981   |  | 25b. REGISTRAR'S SIGNATURE  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 8 1 1 0 8 9 6   |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ROBERT - J. HOOVEN  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>4 8 81   |   |  | 2b. HOUR<br>1.50 PM   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JAN 8 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CASHIER          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ADVENTIST  |  |
| 13a. USUAL RESIDENCE (IF HUSBAND, WIFE OR OTHER PERSON, GIVE RESIDENCE BEFORE ADDRESSING)<br>13b. STATE<br>Maryland   |  |   |  |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert L. Hooven.  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Carrie Lessie  |   |  |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  |   |  |   | 16a. SOCIAL SECURITY NO.<br>060-07-H715  |   | 17. INFORMANT 1206 Boyce Ave, Baltimore, Md.<br>Cornelia Evans. ( Daughter )                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) sudden cardio pulmonary arrest<br>5070 DUE TO, OR AS A CONSEQUENCE OF (b) asperated pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c) Organic Brain syndrome                   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4/8/81<br>3/31/81<br>years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to 4/8/81, 19, that (I) (we) last saw the deceased alive on 4/8/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br> MD  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4/8/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSOOTH LEKAGUL MD  |  |   |  |   | 22e. ADDRESS<br>7425 arlington Rd, Bethesda Md   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation.   |  |   | 23b. DATE<br>4-14-81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Crematory  |   | 23d. LOCATION Prince Geo. Md. Bladensburg Rd. STATE  |   |  |
| 24. FUNERAL DIRECTOR<br>   |  |   |  |   | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>APR 20 1981   |   |  |   |  |

1300 Bruce Ave, Baltimore, Md.  
Mrs. Cora E. Evans (Daughter)

Hoover.

254 Carroll St. N. D. D. D.  
Tabor's Funeral Home.  
Lincoln, Nebraska, 68502  
Lynne Geo. W.



# 14, 5555, 5/11/81 mk

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

10897

FOR  
STATE  
REGISTRAR

|  |         |  |   |  |   |                                      |   |  |
|--|---------|--|---|--|---|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  | 2a. DATE KNOWN OF DEATH                                     |  |   | 2b. HOUR                             |   |  |
| James Eugene Horan   |         |  | MONTH DAY YEAR<br>4 29 81                                   |  |   | 7:40 P.M.                            |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   | IF UNDER 1 YR.   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD             |   |  |
| Male   | White   | AUG 18, 1962   | 18 YRS.   |  |   | MONTH DAY YEAR<br>4 29 81            |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| PENNSYLVANIA   |         | U.S.A.   |   |  |   | Montgomery County MD.                |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |   |  |
| Bethesda   |         | Suburban Hospital  |   | STUDENT  |   | VA. TECH                             |   |  |
| 13a. STATE   |         |  | 13b. CITY OR TOWN   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                  |   |  |
| MARYLAND   |         |  | MONTGOMERY  | SILVER SPRING  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 11905 SELFRIDGE ROAD                 |   |  |
| 14. FATHER'S NAME  |         |  | 15. MOTHER'S MAIDEN NAME                                    |  |   |                                      |   |  |
| EUGENE Joseph MORAN Horan  |         |  | BARBARA SHELLICK  |  |   |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT ADDRESS   |                                      |   |  |
| NO   |         |  | 217-94-7480   |  | EUGENE J. HORAN SAME AS 13 FATHER   |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |   |  |   |                                      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY:  |         |  |   |  |   |                                      |   |  |
| IMMEDIATE CAUSE (a) Craniocerebral Injuries  |         |  |   |  |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |   |  |   |                                      |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |   |  |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |   |  |   |                                      |   |  |
| (c)  |         |  |   |  |   |                                      |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |   |  |   |                                      |   |  |
| 19a. DATE OF OPERATION   |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |                                      | 20. AUTOPSY?  |  |
|  |         |  |   |  |   |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |   |  |
|  |         |  | HOUR MONTH DAY YEAR<br>7:08 P.M. 4 29 81                    |  | Driver of auto in auto/auto collision   |                                      |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |                                      |   |  |
|  |         |  | road  |  | Rt. 270 & Rt. 495 Montgomery Maryland   |                                      |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |   |  |   |                                      |   |  |
| ACTUAL SIGNATURE   |         |  | TITLE (SPECIFY)   |  |   | DATE SIGNED                          |   |  |
| Margarita A. Korell, M.D.  |         |  | Assistant   |  |   | 4/30/81                              |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  | ADDRESS   |  |   |                                      |   |  |
|  |         |  | 111 Penn Street, Baltimore, MD 21201                        |  |   |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      | 23d. LOCATION   |  |
| BURIAL   |         |  | 5/2/81  |  | GATE OF HEAVEN  |                                      | SILVER SPRING MONT MD.  |  |
| 24. FUNERAL DIRECTOR NAME  |         |  | 25a. DATE REC'D. BY REGISTRAR                               |  |   | 25b. REGISTRAR'S SIGNATURE           |   |  |
| FRANCIS J. COLLINS   |         |  | MAY 4 1981  |  |   | F. J. Collins                        |   |  |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901   |         |  |   |  |   |                                      |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
15M 2/80

3501

22

1892 J. YAN





Wife

Wife

Dec. 20, 1948

82

California

LA

Attorney

acc

My home, Monterey, California

1111 Forest Ave, San Jose, Calif.

One

Black

Hand

Two

White

White

1111 Forest Ave, San Jose, Calif.  
1111 Forest Ave, San Jose, Calif.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   | 8 ANTHONY HYTLA  |  |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ANTHONY</b>   |  |  | 2a. DATE OF DEATH MONTH <b>4</b> DAY <b>11</b> YEAR <b>81</b> 7b. HOUR <b>10:30AM</b> |  |  |
| 3. SEX <b>Male.</b>   | 4. RACE <b>White.</b>                        | 5. DATE OF BIRTH MONTH <b>May</b> DAY <b>16,</b> YEAR <b>1889</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery.</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Galthersburg.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Assisted Living Home.</b>   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steel Mill Employee Ret.</b>          |  |
| 13a. STATE <b>Maryland.</b>   |  | 13b. COUNTY <b>Pr. Geo.</b>  | 13c. CITY OR TOWN <b>Hyattsville.</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 14. FATHER'S NAME FIRST <b>Not Available.</b> MIDDLE <b>Not Available.</b> LAST <b>Not Available.</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Not Available.</b> MIDDLE <b>Not Available.</b> LAST <b>Not Available.</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>  |  | 16b. SOCIAL SECURITY NO. <b>193 07 4863</b>  |   | 17. INFORMANT ADDRESS <b>Charles Hytla. ( Son ) ( 13 e )</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC ORGANIC BRAIN</b><br><b>4409</b> DUE TO, OR AS A CONSEQUENCE OF <b>SYNDROME</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> , 19 <b>80</b> , to <b>4/11</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/19</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |
| 22b. SIGNATURE <b>R.C. DADARIO MD</b> DEGREE  |  |  |   | 22c. DATE SIGNED <b>4/11/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.C. DADARIO</b>   |  |  |   | 22e. ADDRESS <b>5413 CEDAR LANE, BETHESDA, MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial.</b>  |  | 23b. DATE <b>April 15, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Adelberts</b>  |  |
| 23d. LOCATION CITY OR TOWN <b>Pittsburg</b> COUNTY <b>Penna.</b> STATE  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Tahoma Funeral Home</b> ADDRESS <b>Tahoma Pub. Co.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 14 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Anthony Hytla</b>  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF DEATH IS DUE TO NATURAL CAUSES, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                             |   |   |   |  |  |   |  |   | REG. NO. 10900 |  |
|--|-----------------------------|---|---|---|--|--|---|--|---|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kenneth W. Ihmle</b>  |                             |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>April 3, 1981</b> |   | 2b. HOUR <b>8:45 P.M.</b>  |   |                |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>June 2, 1958</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS YEARS <b>22</b>              | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>4 3 1981</b>   |   | 2d. HOUR <b>8:45 P.M.</b>  |   |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>   |   |  |   |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Gaithersburg</b>   |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>19222 Racine Court</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>              |   |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Montgomery Gaithersburg</b>  |                             |   |   |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |   | 13e. STREET ADDRESS<br><b>19222 Racine Court</b>                   |   |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gordon F. Ihmle</b>   |                             |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Evelyn Lee</b>          |   |  |  |   |  |   |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-78-9262</b>   |   | 17. INFORMANT ADDRESS<br><b>Gordon F. Ihmle, Same as 13</b>   |  |  |   |  |   |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>1869</b><br>(b) <b>Diffuse Carcinomatous</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>TESTICULAR CHORIOCARCINOMA</b>               |                             |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Acute</b><br><b>1 Yr.</b><br><b>INDEF.</b> |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                             |   |   |   |  |  |   |  |   |                |  |
| 19a. DATE OF OPERATION   |                             |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |   |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                             |   | 21b. TIME OF INJURY<br>HOUR AM. MONTH DAY YEAR<br><b>8:45 P.M. 4 3 1981</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>DIED AT HOME</b> |  |   |  |   |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                             |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>19222 Racine Ct Gaithersburg Mont MD</b>     |  |   |  |   |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |   |   |   |  |  |   |  |   |                |  |
| ACTUAL SIGNATURE<br><b>Francis C. Mayle, M.D.</b>  |                             |   | TITLE (SPECIFY)<br><b>Deputy</b>  |   |  | MEDICAL EXAMINER<br><b>8200 Wisconsin Avenue</b>   |   |  | DATE SIGNED<br><b>April 4, 1981</b>   |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Francis C. Mayle, M.D.</b>  |                             |   | ADDRESS<br><b>Bethesda, Maryland 20014</b>                                  |   |  |  |   |  |   |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                             |   | 23b. DATE<br><b>April 9, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Live Oak Memorial Gardens</b>                               |  |   | 23d. LOCATION<br>CITY OR TOWN STATE<br><b>Charleston, Carolina</b> |   |                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Rockville, Maryland</b>  |                             |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 08 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony...</b> |  |   |                |  |





*[Faint handwritten text, possibly a signature or initials]*

1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

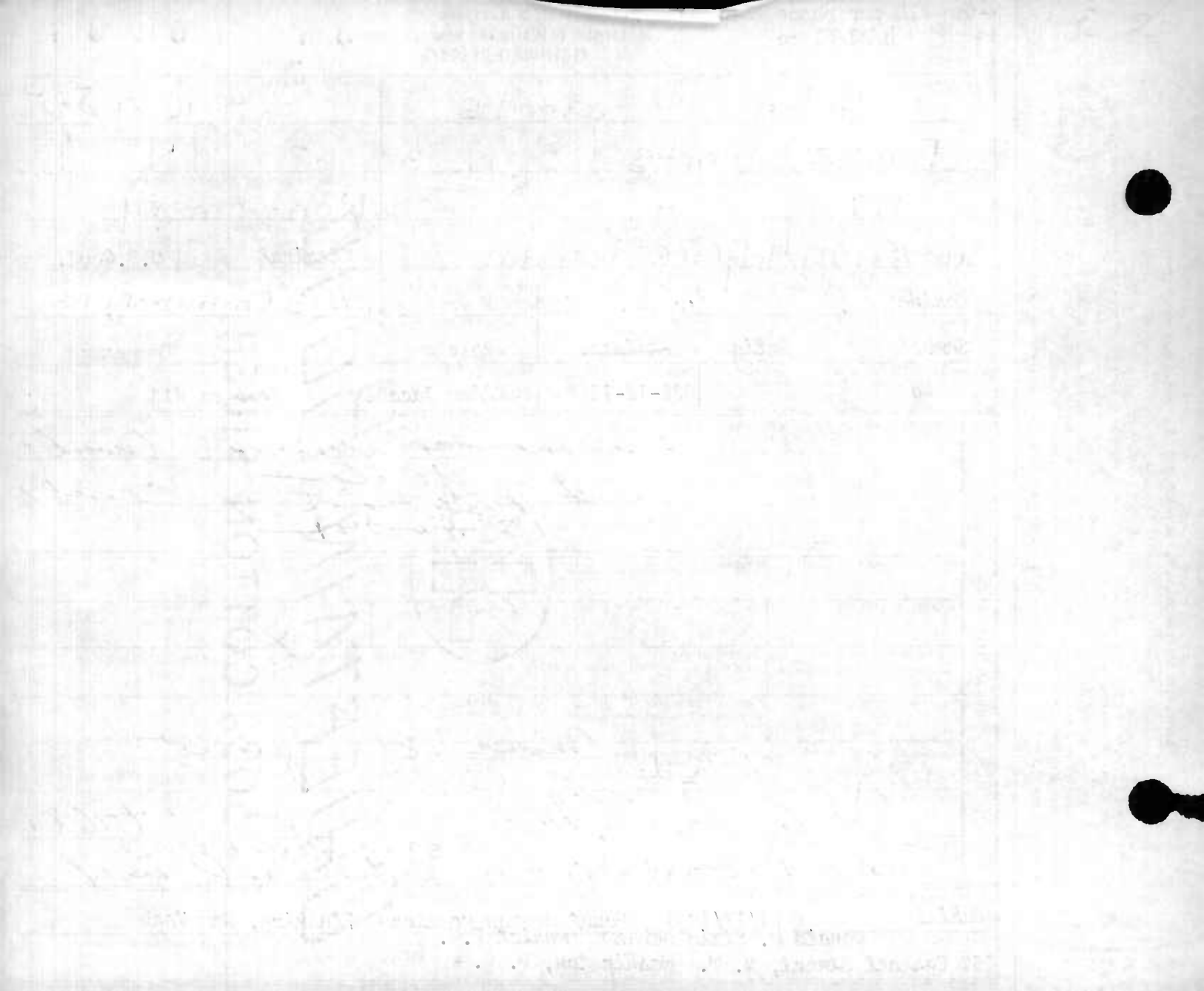
BP

DHMH-16 30M 2/80  
(VRA 15, 4)

Item #14 per phone call w/ Fun. Home STATE OF MARYLAND  
1- FOR STATE REGISTRAR b/27/81 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 0 9 0 1  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |
|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Helen Jacobs</b>  |   | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>16</b> YEAR <b>81</b>  |   | 2b. HOUR <b>8:30</b> M  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>17</b> YEAR <b>13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NY</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerical</b>             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>  |
| 13a. STATE<br><b>Florida</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Hallandale</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1817 South Ocean Drive, #619</b>  |
| 14. FATHER'S NAME<br>FIRST <b>Samuel</b> MIDDLE <b>Selig</b> LAST <b>Steiner</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rose</b> MIDDLE <b>Popperman</b> LAST  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>082-12-1849</b>  |   | 17. INFORMANT<br><b>William Jacobs</b> ADDRESS<br><b>Same as #13</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Disseminated Carcinoma</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>of Colon with Intestinal Obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |   |   |   |   |
| 22b. SIGNATURE<br><b>John A. Salotto M.D.</b>  |   | 22c. DATE SIGNED<br><b>4-16-81</b>  |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22e. ADDRESS<br><b>5225 Proctor Highway, Bethesda, Md 20814</b>  |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   |   |
| 23b. DATE<br><b>4/17/1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Hebron Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Flushing, New York</b>   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Donald M. Stein</b> ADDRESS <b>232 Carroll Street, N. W. Washington, D. C.</b>   |   | 25. DATE REC'D BY REGISTRAR <b>APR 20 1981</b> REGISTRAR'S SIGNATURE  |   |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER - ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 10902                                 |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DECEASED NAME (TYPE OR PRINT) <b>Ruth K. Jacoby</b>  |  |  |  |  |  | 2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>April 26, 1981</b> |  | 2c. HOUR <b>M</b>                              |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>Dec. 23, 1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.   |  | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>        |  | 7d. DATE PRONOUNCED DEAD <b>April 26, 1981</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7051 Carroll Ave. Apt-302</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Takoma Park</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>7051 Carroll Ave. Apt-302</b>   |  |  |  |
| 14. FATHER'S NAME FIRST <b>Homer</b> MIDDLE <b>Kinney</b> LAST <b>Viola</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>McBride</b> MIDDLE <b>Edmonston</b> LAST <b>Rd.</b>  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)   |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>577-01-7175</b>  |  |  |  | 17. INFORMANT <b>Ruth E. Morgan (Daughter)</b>   |  |  |  | ADDRESS <b>Hyattsville, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>None</b>  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>   |  |  |  | TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>4/27/81</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>  |  |  |  | ADDRESS <b>1919 Seminary Rd. Sil. Spg. Md.</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>4-29-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>P.G.</b> STATE <b>Maryland</b>          |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A.</b> ADDRESS <b>Hyattsville, Md.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 28 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                                     |  | 8110903  |  |  |  |
|---|--|--|--|---|--|-------------------------------------|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |                                     |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |                                     |  | 2b. HOUR   |  |  |  |
| CHARLES W. JONES, SR.   |  |  |  | 4 21 81   |  |                                     |  | 4:42 PM  |  |  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)      |  | 7 UNDER 1 YEAR   |  | 7 UNDER 24 HRS   |  |
| MALE  |  | WHITE  |  | 9 01 92   |  | 88                                  |  | MONTHS   |  | DAYS   |  |
| 12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |
| MARYLAND  |  | U.S.A.   |  |   |  | MONTGOMERY                          |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| SILVER SPRING   |  | HOLY CROSS HOSPITAL  |  | ELECTRICIAN   |  | WASH. TERMINAL CO.                  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13b. INSIDE CITY LIMITS?  |  |                                     |  | 13c. STREET ADDRESS  |  |  |  |
| 13a. STATE  |  |  |  | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                                     |  | 2417 FORDHAM PLACE   |  |  |  |
| 13a. COUNTY   |  |  |  | 13c. CITY OR TOWN   |  |                                     |  |  |  |  |  |
| MARYLAND  |  |  |  | PRI GEO   |  |                                     |  | HYATTSVILLE  |  |  |  |
| 14 FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                     |  |  |  |  |  |
| JOHN T. JONES   |  |  |  | EMMA M. MALONE  |  |                                     |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |                                     |  | 17 INFORMANT ADDRESS   |  |  |  |
| YES   |  |  |  | WW I  |  |                                     |  | 718-14-7081  |  |  |  |
|   |  |  |  | ROBERT E. JONES   |  |                                     |  | SAME AS 13 SON   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 2020 SEPTIC SHOCK  |  |  |  |   |  |                                     |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b). PNEUMONITIS   |  |  |  |   |  |                                     |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c). LIVER FAILURE 2° TO PNEUMOTICERAD   |  |  |  |   |  |                                     |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). LYMPHOCYTIC LYMPHOMA   |  |  |  |   |  |                                     |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                     |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | Bowel Obstruction   |  |                                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
|   |  |  |  | P.M. 19   |  |                                     |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|   |  |  |  |   |  |                                     |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/11 19 81, to 4/21 19 81, that (I) (we) lost saw the deceased at 4/21 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |                                     |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |                                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| MARTIN H. EICHLEN   |  |  |  |   |  |                                     |  |  |  | 4/21/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |                                     |  |  |  |  |  |
| MARTIN H. EICHLEN   |  |  |  | 3915 FARRISON DR  |  |                                     |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| BURIAL  |  |  |  | 4/24/81   |  | FT. LINCOLN                         |  | BRENTWOOD PRI GEO MD.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR       |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| FRANCIS J. COLLINS  |  |  |  |   |  | APR 23 1981                         |  | [Signature]  |  |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  |   |  |                                     |  |  |  |  |  |

00001

9-18-58

88

28-10-1

171

10000-405-2-10000-10000

10000-405-2-10000-10000

10000-405-2-10000-10000

10000-405-2-10000-10000

10000-405-2-10000-10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |   |  |  |  | 8110905  |  |
|---|--|--|---|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | REG. NO.   |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Carolyn L. Kennedy</b>   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-4-81</b>  |   |  |  | 2b. HOUR<br><b>7 PM</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 15, 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>67</b>                                 |  | IF UNDER 1 YEAR MONTHS DAYS<br><b></b>   |  | IF UNDER 24 HRS. HOURS MIN.<br><b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Hampshire</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>              |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                               |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Mont. Co.</b>                                     |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>501 Ashford Road</b>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lewis - Heath</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alice - Haskell</b>   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>002-05-7975</b>   |   | 17. INFORMANT ADDRESS<br><b>William J. Kennedy Jr. (Husband) Same as #13.</b>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive lung disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>&amp; Cor pulmonale</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>10 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>April 1971</b> to <b>4-4-81</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>4-4-81</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (If <del>(we)</del> did not view the body after death.  |  |  |   |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE  |  |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>4.4.81</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Saron Berger, M.D.</b>  |  |  |   |   | 22e. ADDRESS<br><b>8870 CAMERON STREET SILVER SPRING, MD. 20910</b>  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>April/6/81</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland, P.G. Co., Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Chambers Funeral Home Riverdale, Maryland</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1981</b>  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |  |  |  |



APR 10 1981

Ref: 100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 1 1 0 9 0 4  |  |
|---|---|---|--|--|--|
| CERTIFICATE OF DEATH  |   | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>William NMN JONES</i>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR HOUR<br><i>4 8 81 8 P.M.</i> |  |  |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>B</i>                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 10 06</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery Co.</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park, Md.</i>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hospital</i>           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>RETIRED</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <i>MD.</i> 13c. CITY OR TOWN <i>P.G.</i> 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><i>7973 RIGGS RO.</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>SAM JONES</i>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>LUKE KING</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |   | 16b. SOCIAL SECURITY NO.<br><i>578 07 5449</i>  |  | 17. INFORMANT ADDRESS<br><i>VELMARINE JONES 7973 RIGGS RO.</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)               |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Septic; Cardiogenic shock</i>   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>4/8/81</i>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/8/81</i> , 19 <i>81</i> , to <i>April 8 1981</i> , that (I) (we) lost<br>saw the deceased alive on <i>4/8/81</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Miguel A. Rodriguez</i>  |   | DEGREE  |  | 22c. DATE SIGNED<br><i>04/8/81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Miguel A. Rodriguez</i>   |   | 22e. ADDRESS<br><i>8634 FLOWER AVE. Takoma Park</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>   |   | 23b. DATE<br><i>4-14-81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>HARMONY CEM.</i>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>LANDOVER MD.</i>   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 14 1981</i>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Watson F.H. 3435-14th St. N.W. Wash. D.C.</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

10

Q

W

Q

W

Q

W

Q

W

Q

W

Q



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |                         |  |                                    |  |                   |  |   |  |  |
|---|--|--|-------------------------|--|------------------------------------|--|-------------------|--|---|--|--|
| 1 - STATE REGISTRAR   |  |  |                         |  | 8 1 10906                          |  |                   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |                         |  | 2a. DATE OF DEATH                  |  |                   |  |   |  |  |
| FIRST MIDDLE LAST   |  |  |                         |  | MONTH DAY YEAR HOUR                |  |                   |  |   |  |  |
| Anne K. KEVANY  |  |  |                         |  | 4 7 81 7:15 AM                     |  |                   |  |   |  |  |
| 3. SEX  |  | 4. RACE  |                         | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |                   | 7. IF UNDER 1 YEAR                                       |   |  |  |
| Female  |  | Caucasian  |                         | MONTH DAY YEAR   |                                    | 80 YRS.  |                   | IF UNDER 24 HRS.   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                   |  |   |  |  |
| Ireland   |  | U.S.A.   |                         |  |                                    | MONTGOMERY MD.   |                   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                         |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                   | 12b. KIND OF BUSINESS OR INDUSTRY                        |   |  |  |
| Wheaton   |  | University Nursing Home  |                         |  |                                    | HOUSEWIFE  |                   |  |   |  |  |
| 13a. STATE  |  |  |                         |  | 13b. COUNTY                        |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?  |  |  |
| MARYLAND  |  |  |                         |  | MONTGOMERY                         |  | GAITHERSBURG      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |  |                         |  | 15. MOTHER'S MAIDEN NAME           |  |                   |  |   |  |  |
| FIRST MIDDLE LAST   |  |  |                         |  | FIRST MIDDLE LAST                  |  |                   |  |   |  |  |
| JAMES MALONEY   |  |  |                         |  | KATHERINE UNKNOWN                  |  |                   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |                         |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT     |  |   | ADDRESS  |  |
| NO  |  |  |                         |  | 568-05-0069                        |  | SON               |  |   | 615 BENNINGTON LA.   |  |
|   |  |  |                         |  |                                    |  | MICHAEL J. KEVANY |  |   | SILVER SPRING, MD.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                         |  |                                    |  |                   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |                         |  |                                    |  |                   |  |   |  |  |
| IMMEDIATE CAUSE (a) Pneumonia   |  |  |                         |  |                                    |  |                   |  |   |  |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF   |  |  |                         |  |                                    |  |                   |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:  |  |  |                         |  |                                    |  |                   |  |   |  |  |
| (b) ASCVD - 5 yrs duration  |  |  |                         |  |                                    |  |                   |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                         |  |                                    |  |                   |  |   |  |  |
| (c)   |  |  |                         |  |                                    |  |                   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                         |  |                                    |  |                   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |  |                   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |                         |  |                                    |  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                   |  |   |  |  |
|   |  |  |                         | P.M. 19  |                                    |  |                   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                    | 21f. LOCATION  |                   | CITY OR TOWN   |   | COUNTY STATE   |  |
|   |  |  |                         |  |                                    | STREET   |                   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 75, to April 19 81, that (I) (we) last saw the deceased alive on 3/31 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                         |  |                                    |  |                   |  |   |  |  |
| 22b. SIGNATURE  |  |  |                         | DEGREE   |                                    |  |                   | 22c. DATE SIGNED   |   |  |  |
| Myron Lenkin  |  |  |                         |  |                                    |  |                   | 4/7/81   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |                         | 22e. ADDRESS   |                                    |  |                   |  |   |  |  |
| MYRON LENKIN, MD  |  |  |                         | 2309 Shorefield Rd. Wheaton, Md  |                                    |  |                   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE               |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                   | 23d. LOCATION  |   | CITY OR TOWN COUNTY STATE                                      |  |
| BURIAL  |  |  | APR. 12, 1981           |  | EASKEY CEMETERY                    |  |                   | EASKEY SLIGO   |   | IRELAND  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  | 24b. ADDRESS            |  | 25a. DATE REC'D. BY REGISTRAR      |  |                   | 25b. SIGNATURE   |   |  |  |
| FRANCIS J. COLLINS  |  |  | 500 UNIVERSITY BLVD. W. |  | SILVER SPRING, MD.                 |  |                   | APR 09 1981  |   |  |  |



RECEIVED  
JAN 10 1964

TO  
FROM  
SUBJECT  
DATE  
INITIALS



801 P 894



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                     |  |  |  |   |  |  |  | 10907   |  |
|---|--|-------------------------------------|--|--|--|---|--|--|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR  |  |                                     |  |  |  |   |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kathryn D. Keys</b>  |  |                                     |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <b>Apr. 1, 1981 8:56 a.m.</b> |  | 2b. DATE KNOWN ESTI- MATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <b>April 1, 1981 8:56 a.m.</b> |  |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Cauc.</b>                |  | 5. DATE OF BIRTH <b>Aug. 1, 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD <b>April 1, 1981</b>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>   |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD. |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>              |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                     |  |  |  |   |  |  |  |   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. CITY OR TOWN <b>Montgomery</b> |  | 13c. CITY OR TOWN <b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>4521 East West Highway</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William Dunn</b>   |  |                                     |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Colgan</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |  |                                     |  | 16b. SOCIAL SECURITY NO. <b>578-03-6724</b>  |  | 17. INFORMANT ADDRESS <b>Ann E. Dunn, Same as #13</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>4960 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Chronic Obstructive Pulmonary Disease</b><br>8-10 yrs } DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                  |  |                                     |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b>      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |                                     |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION _____  |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>0710 PM 4 1 1981</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Found in Apartment</b>   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4521 East West Hwy. Bethesda Mont MD</b>  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                     |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Francis C. Mayle</i>  |  |                                     |  | TITLE (SPECIFY) <b>M.D. Dept</b>   |  |   |  | DATE SIGNED <b>April 2, 1981</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayle, M.D.</b>   |  |                                     |  | ADDRESS <b>8200 Wisconsin Ave. Bethesda, MD</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                                     |  | 23b. DATE <b>April 4, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert A. Humphrey</b> ADDRESS <b>Homes, P.A. Bethesda, Maryland</b>   |  |                                     |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 06 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <i>Robert A. Humphrey</i>   |  |   |  |





*[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 18 G554 4/15/81 dad

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

10908

|   |                         |   |   |   |   |   |   |  |
|---|-------------------------|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SCHERIE N. KIRSCHENMANN</b>  |                         |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>4 1 19 81</b> |   |   | 2b. HOUR <b>8:08</b>  |   |  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH <b>Feb</b> DAY <b>20</b> YEAR <b>1981</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTH <b>1</b> DAY <b>12</b> YRS.  | IF UNDER 1 YR.<br>MONTHS <b>1</b> DAYS <b>12</b>  | IF UNDER 24 HRS.<br>HOURS <b>1</b> MIN. <b>12</b>     | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>19 81</b>     |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b>              |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville.</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hosp.</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| USUAL RESIDENCE (IF IN BALTIMORE, GIVE STREET ADDRESS)<br>13a. STATE <b>Maryland.</b> 13b. COUNTY <b>Montg.</b> 13c. CITY OR TOWN <b>Rockville.</b>   |                         |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>743 Monroe St. Apt. 103</b> |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Ronald W.</b> MIDDLE <b>Kirschenmann</b> LAST   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Gini C.</b> MIDDLE <b>Lindelof.</b> LAST   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No.</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>—</b>  |   | 17. INFORMANT<br>ADDRESS <b>Ronald Kirschenmann (13 e)</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>Acute bronchopneumonia</b><br><b>4850</b><br>IMMEDIATE CAUSE (a) <b>-Sudden Infant Death Syndrome-</b><br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>                        |                         |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Hormez R. Guard</b>  |                         | TITLE (SPECIFY)<br><b>Assistant</b> M.D. MEDICAL EXAMINER   |   |   |   |   | DATE SIGNED<br><b>4/1/81</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |                         | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>  |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |                         | 23b. DATE<br><b>4-3-1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN <b>Silver Spring, Montg. Co., Md.</b> COUNTY STATE    |  |
| 24. FUNERAL DIRECTOR<br><b>Takoma Funeral Home.</b>   |                         | 25a. DATE RECEIVED BY REGISTRAR<br><b>APR 6 1981</b>  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>      |   |   |  |
| 25c. ADDRESS<br><b>254 Carroll St. N. W. D.</b>   |                         |   |   |   |   |   |   |  |

BP

KIRCHENSTADT

STADT

1 12

1 12

X

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

STADT

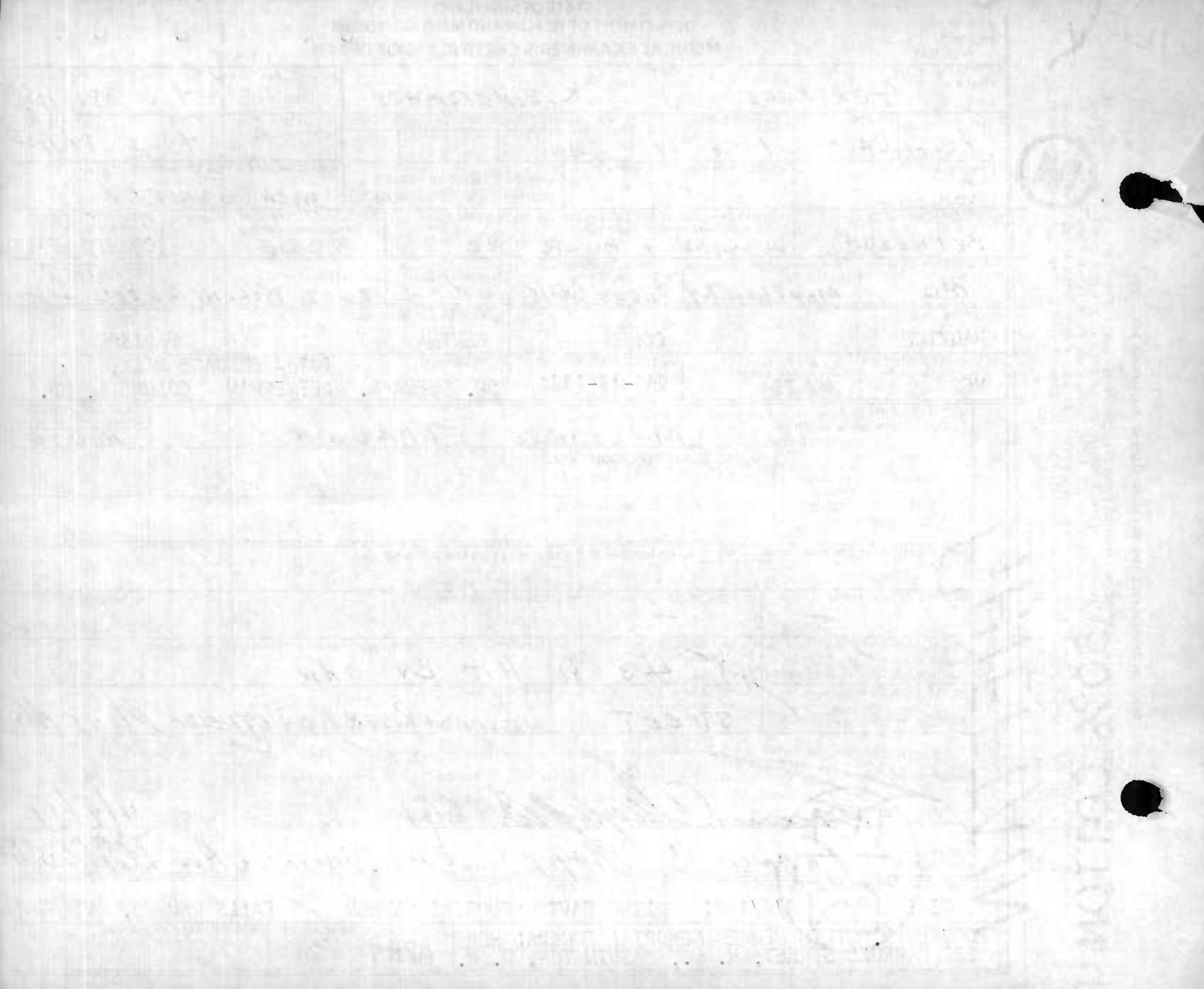
STADT

STADT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                     |   |  |  |   |  |  |   |  | REG. NO. 10909  |  |
|--|---------------------|---|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GERTRUDE J KLEINERMAN</b>   |                     |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>4</b> DAY <b>3</b> YEAR <b>1981</b> |  |   | 2b. HOUR <b>1158</b>   |  |   |  |   |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>CAUC</b> | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>6</b> YEAR <b>19</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.   | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD <b>4 3 1981</b>   |  | 2d. HOUR <b>1158</b>  |  | M <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BETHESDA</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WILLARD + RIVER RD</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>                   |  | 12b. <b>MONTGOMERY</b> COUNTY HEALTH DEPARTMENT                                       |  |   |  |
| 13a. STATE <b>MD</b>   |                     | 13b. COUNTY <b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN <b>CHEVY CHASE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>7207 ROLLINGWOOD DR</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>MAURICE</b> MIDDLE <b></b> LAST <b>COHEN</b>   |                     |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BERTHA</b> MIDDLE <b></b> LAST <b>DAVISON</b>   |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>  |                     | (IF YES, GIVE WAR OR DATES) <b>WW II</b>  |  | 16b. SOCIAL SECURITY NO. <b>066-18-1386</b>  |   | 17. INFORMANT <b>10764 CORDAGE WALK, DR. DEENA A. KLEINERMAN COLUMBIA, MD.</b>               |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE TRAUMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |                     |   |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                     |   |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION <b></b>   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>   |  |  |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>1158 P.M. 4 3 1981</b>   |                     | 21b. TIME OF INJURY <b>1158 P.M. 4 3 1981</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>HIT BY CAR</b>  |   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b></b>  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>STREET</b>   |  | 21f. LOCATION <b>WILLARD + RIVER RD BETHESDA MONT MD</b>   |   |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |   |  |  |   |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Francis C. Mayke</b>   |                     | TITLE (SPECIFY) <b>Det</b>  |  |  |   |  |  | DATE SIGNED <b>4/4/81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>FRANCIS C MAYKE</b>   |                     | ADDRESS <b>8200 WISCONSIN AVE BETHESDA</b>  |  |  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |                     | 23b. DATE <b>4/6/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>   |   |  |  | 23d. LOCATION CITY OR TOWN <b>FALLS CHURCH, VIRGINIA</b> COUNTY <b></b> STATE <b></b> |  |   |  |
| 24. FUNERAL DIRECTOR <b>DONALD M. STEIN</b>  |                     | ADDRESS <b>HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>APR 7 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

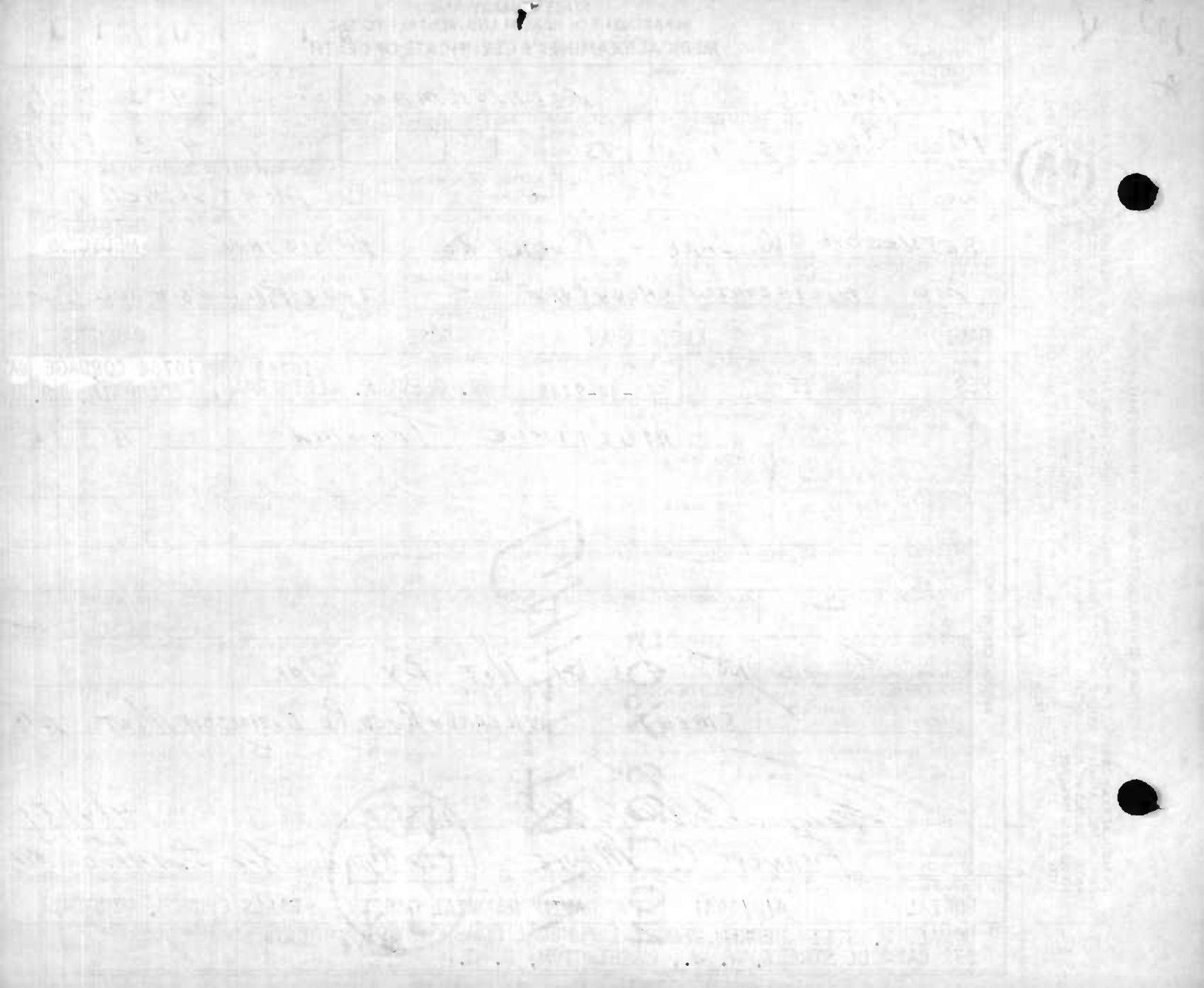
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                        |   |  |   |  |   |  |   |  |   |  |
|---|------------------------|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MORRIS</b>   |                        | FIRST   |  | MIDDLE  |  | LAST <b>KLEINERMAN</b>  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>4 3 1981</b> |  | 2b. HOUR <b>11:57 PM</b>  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>CAUC</b> | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>18</b> YEAR <b>07</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>73</b> YRS.   |  | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                 |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>4</b> DAY <b>3</b> YEAR <b>1981</b>                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONT GOMERY</b> MD.                                  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WILLARD + RIVER RD</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PHYSICIAN</b>   |  | 12b. KIND OF BUSINESS<br><b>PRIMARY PRACTICE</b>  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                        |   |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br><b>MD</b>   |                        | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>CHEVY CHASE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7207 ROLLINGWOOD DR</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>DAVID</b> MIDDLE <b>KLEINERMAN</b> LAST <b>KLEINERMAN</b>   |                        |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ROSE</b> MIDDLE <b>PARNESS</b> LAST <b>PARNESS</b>         |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>  |                        | 16b. SOCIAL SECURITY NO.<br><b>220-44-2448</b>  |  | 17. INFORMANT<br><b>DR. DEENA A. KLEINERMAN, 10764 CORDAGE WALK, COLUMBIA, MD.</b>  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                        |   |  |   |  |   |  |   |  |   |  |
| PART 1 DEATH WAS CAUSED BY:   |                        |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) <b>8147 MULTIPLE TRAUMA</b>   |                        |   |  |   |  |   |  |   |  | <b>ACUTE</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |                        |   |  |   |  |   |  |   |  |   |  |
| (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |                        |   |  |   |  |   |  |   |  |   |  |
| (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |                        |   |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                        |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                        |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                        |   |  | 21b. TIME OF INJURY<br>HOUR <b>1158</b> P.M. MONTH <b>4</b> DAY <b>3</b> YEAR <b>1981</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>HIT BY CAR</b>  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                        |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>STREET</b>  |  |   |  | 21f. LOCATION<br>STREET <b>WILLARD + RIVER RD</b> CITY OR TOWN <b>BETHESDA</b> COUNTY <b>MONT</b> STATE <b>MD</b>   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                        |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Francis C. Mayle</b>  |                        |   |  | TITLE (SPECIFY)<br><b>DEPT</b> M.D.   |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED <b>4/4/81</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>FRANCIS C. MAYLE</b>  |                        |   |  | ADDRESS <b>8200 WILSON AVE BETHESDA MD</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE) <b>BURIAL</b>   |                        |   |  | 23b. DATE<br><b>4/6/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEMORIAL GARDEN</b>                         |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>FALLS CHURCH, VIRGINIA</b> COUNTY <b>FAIRFAX</b> STATE <b>VA</b> |  |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b><br><b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>  |                        |   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>APR 7 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Taylor E. Kooker</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1981</b>           |   |  | 2b. HOUR<br><b>9<sup>55</sup> A.M.</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 20, 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co.</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(12b. KIND OF BUSINESS OR INDUSTRY)<br><b>Hearing Polisher</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Manufacturing</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Montgomery</b>                                       |   | 13c. CITY OR TOWN<br><b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Kooker</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Albert</b>  |   |  | 17. ADDRESS<br><b>11815 Gainsborough Rd.<br/>Mrs. William Nagle, Rockville, Md.</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>199-01-9802</b>                         |   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY TUBERCULOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>CHLORETISIA.</b> |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Apr 14, 1981</b> to <b>Apr 16, 1981</b> , that (I) (we) last saw the deceased alive on <b>April 16, 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                     |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert T. Thibadeau</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-16-81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT T. THIBADEAU</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>ROCKVILLE, MARYLAND</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>April 20, 1981</b>                                     |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Grove Presby-terian Cemetery</b> |  | 23d. LOCATION<br>CITY COUNTY STATE<br><b>Forest Grove, Pennsylvania</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |  |  |

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

11 0 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |   |   |  |   |  |
|--|--|---|--|--|---|---|--|---|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  |   |  |  | REG. NO.  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>YETTA</b> FIRST <b>YETTA</b> MIDDLE <b>-</b> LAST <b>KRIEGER</b>   |  |   |  |  | 2a DATE OF DEATH MONTH <b>April</b> DAY <b>5</b> YEAR <b>81</b>                 |   |  |   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Caucasian</b>   |  | 5 DATE OF BIRTH <b>1908</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b>  |  | 7b HOUR <b>11:27 A</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |   | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Education</b>   |  |
| 10 CITY OR TOWN OF DEATH <b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brooke Grove Nursing Home</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>  |   | 12b KIND OF BUSINESS OR INDUSTRY <b>Education</b>   |  |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>New York</b>  |  | 13b COUNTY <b>Kings</b>   |  | 13c CITY OR TOWN <b>Brooklyn</b>   |   | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  | 13e STREET ADDRESS <b>1530 East 18th St.</b>  |  |
| 14 FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b>-</b> LAST <b>KRIEGER</b>  |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST <b>Lena</b> MIDDLE <b>-</b> LAST <b>MITTLEMAN</b> |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b SOCIAL SECURITY NO. <b>101-32-6146-A</b>  |  | 17 INFORMANT <b>Janet Sabin</b>  |   | 166 ADDRESS <b>Old Court House Rd. New Hyde Park, L.I., New York</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b>   |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min.</b><br><b>1 wk.</b><br><b>1 yr.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Cerebral Vascular Hemorrhage</b>   |  |   |  |  |   |   |  |   |  |
| 19a DATE OF OPERATION <b>-</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Jan 22</b> , 19 <b>81</b> , to <b>April 5</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>Apr. 4</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |   |  |
| 22b SIGNATURE <b>Albert S. Whiting</b>   |  |   |  | DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  | 22c DATE SIGNED <b>Apr. 5, 1981</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert S. Whiting</b>  |  |   |  | 22e ADDRESS <b>3533 Pitara Pl Lark MD</b>  |   |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL <b>Removal- Burial</b>  |  | 23b DATE <b>Apr. 6, 1981</b>  |  | 23c NAME OF CEMETERY OR CREMATORY <b>Beth-David Cemetery</b>   |   | 23d LOCATION <b>Elmont-L.I. Nassau New York</b>   |  |   |  |
| 24 FUNERAL DIRECTOR <b>FRANCIS H. BARBER</b>   |  |   |  | LAYTONSVILLE, MD. <b>20760</b>   |   | 25a DATE REC'D. BY REGISTRAR <b>APR 9 1981</b>  |  | 25b REGISTRAR'S SIGNATURE   |  |



*[The following text is extremely faint and largely illegible, appearing to be a handwritten document or a very faded printed page. It seems to contain several paragraphs of text, possibly a letter or a report, but the words are too light to transcribe accurately.]*

16

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

10913

|   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Virgil Eugene KRUGER</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>4 1 81</i>                      |  |  | 2b. HOUR<br><i>2:20 PM</i>  |  |   |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>WHITE</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>SEPT 20, 1906</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><i>74 YRS.</i>                                   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>KANSAS</i>  |  | 8b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY MD.</i>                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BETHESDA</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SUBURBAN HOSPITAL</i> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>SECTION CHIEF</i>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>I.C.C.</i>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |   |  |   |  |
| 13a. STATE<br><i>MARYLAND</i>   |  | 13b. COUNTY<br><i>MONTGOMERY</i>  |  | 13c. CITY OR TOWN<br><i>KENSINGTON</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>10510 PARKWOOD DRIVE</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>LON P. LOMAX</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>MaeBELLE KRUGER</i>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>YES</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW II 577-30-4227</i>   |  | 17. INFORMANT<br><i>ELLEN G. KRUGER</i>  |  | ADDRESS<br><i>SAME AS 13</i>  |  | WIFE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiac standstill</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>cardiogenic shock</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>myocardial infarction</i>   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>5-10 min</i><br><i>60 hrs</i><br><i>6 days</i>                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec</i> , 19 <i>80</i> , to <i>4-1</i> , 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>4-1</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Thomas G. Sinderson, MD</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><i>4-1-81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>THOMAS G. SINDERSON</i>   |  |   |  | 22e. ADDRESS<br><i>11125 ROCKVILLE PIKE, ROCKVILLE, MD, 20852</i>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>4/4/81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>PARKLAWN CEMETERY</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>ROCKVILLE MONT MD.</i>                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>FRANCIS J. COLLINS</i><br>ADDRESS <i>500 UNIVERSITY BOULEVARD W, SILVER SPRING, MD.</i>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 03 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony Babington</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

MEDICAL CERTIFICATION

BP

4300



UNIVERSITY OF MICHIGAN

1900-1901

X

Handwritten signature

1891 10 99A

DHMH - 16-50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO.   |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary Elizabeth Kvamme</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>29</b> YEAR <b>81</b>                                 |  | 2b. HOUR<br><b>11 P.M.</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>15</b> YEAR <b>1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Brook Grove Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>State Employee-Kansas</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  |   |  | 13b. COUNTY<br><b>Mont.</b>  |  | 13c. CITY OR TOWN<br><b>S.S.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Lampson</b> LAST <b></b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Genevieve</b> MIDDLE <b>Johnston</b> LAST <b></b>           |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>None</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>511 09 4337</b>  |  | 17. INFORMANT<br>ADDRESS <b>Same as above</b><br><b>Genevieve Middaugh (Sister)</b>              |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL PULMONARY CONGESTION</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRAL INFARCTIONS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIO SCLEROSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>3 Months</b><br><b>Years</b> |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>DIABETES, NEPHROSCLEROSIS, PYELONEPHRITIS</b>   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                    |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>4/13</b> 19 <b>80</b> , to <b>4/29</b> 19 <b>81</b> , that (1) we lost saw the deceased alive on <b>4/28</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we found (did not see the body after death)  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Ronald E. Lewis</b>   |  |  |  |   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/29/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.P. LEWIS M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>OLNEY, MARYLAND 20832</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Crementation</b>  |  |  |  | 23b. DATE<br><b>4/30/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN <b>Wash. D.C.</b> COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.</b>   |  |  |  |   |  | 25a. DATE OF REGISTRATION<br><b>MAY 4 1981</b>   |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |  |  |  |  |  |  |  |

54  
70  
35  
50  
1

EXAMINER MUST BE NOTIFIED IN ADVANCE OF THE DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

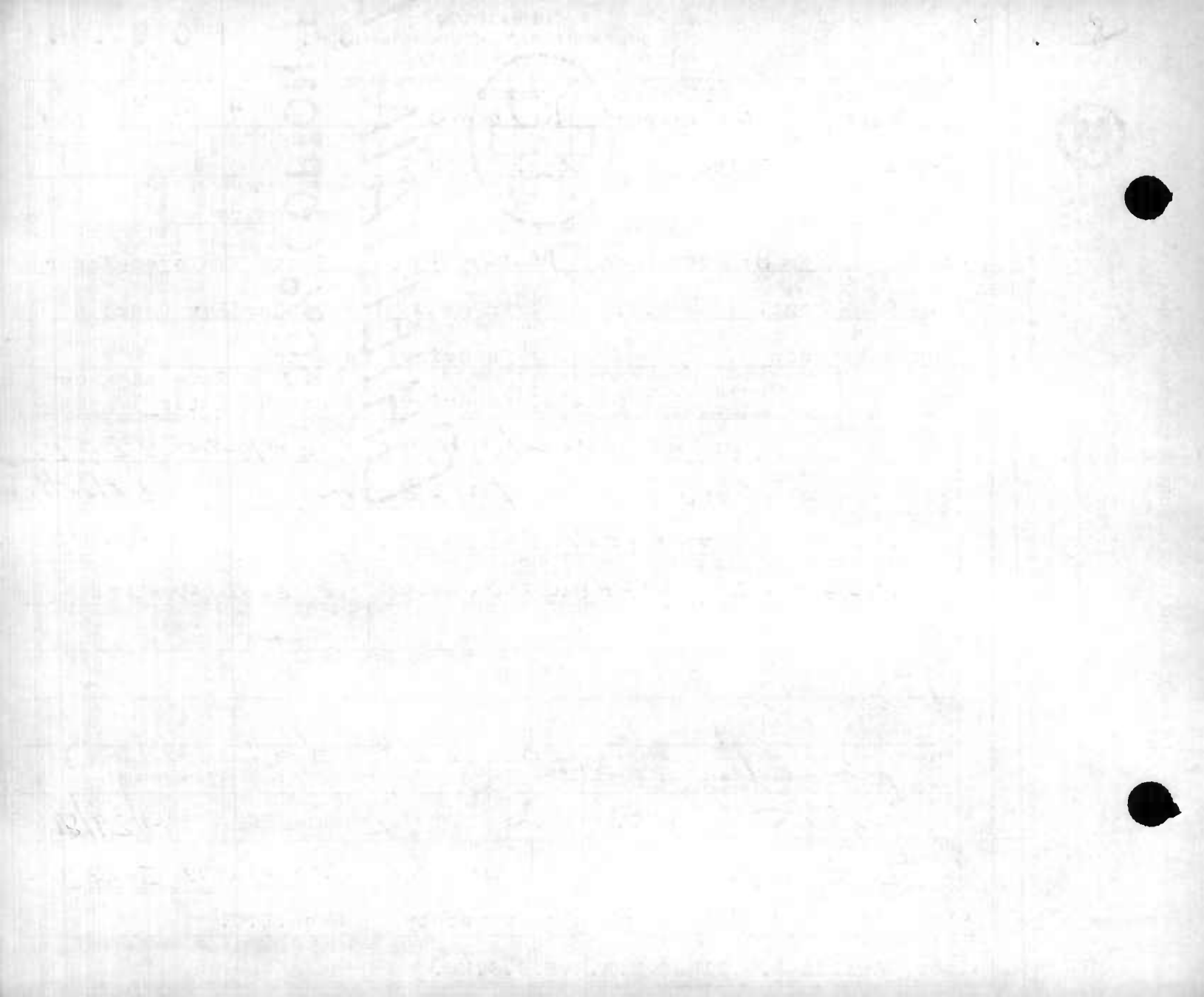
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified in advance of the death.

MEDICAL CERTIFICATION

29

3203  
BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |                  |  |   |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                          |  |  |  |  |  |  |  | REG. NO. 10915   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE M KYLE</b>   |  |                  |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <b>April 21, 1981</b>  |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>12:30 AM</b>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>W</b> |  | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>13</b> YEAR <b>91</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>89 YRS.</b> |  | IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>   |  | 2c. DATE PRONOUNCED DEAD <b>April 21, 1981</b> |  |  |  |  |  |  |  |   |  | 2d. HOUR <b>12:30 AM</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  |                  |  |   |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  |                          |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>                                   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  |                  |  |   |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>  |  |                          |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>MD</b>  |  |                  |  |   |  |  |  |  |  | 13b. COUNTY <b>Mont.</b>   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN <b>Silver Spring</b>  |  |                          |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS <b>8505 Springvale Rd</b>                                       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Clarence M.</b> MIDDLE <b>Kyle</b> LAST <b></b>  |  |                  |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                          |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>WWI</b>  |  |  |  |  |  |  |  |  |  | 17. INFORMANT <b>Joe Kyle (Son)</b> ADDRESS <b>8335 Grubb Rd. Silver Spring Md.</b> |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |                  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 days</b>   |  |  |  |  |  |  |  |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Fracture Rt hip</b> |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>4-2-81</b>  |  |                  |  |   |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture Rt hip</b>   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |  |                  |  |   |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell at home</b>   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |  |   |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>  |  |  |  |  |  |  |  |  |  | 21f. LOCATION STREET <b>Springvale Rd.</b> CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Mont.</b> STATE <b>MD</b>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |   |  |  |  |  |  | TITLE (SPECIFY) <b>Cap</b>   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>April 21, 1981</b>   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John P. Rogers</b> M.D.   |  |                  |  |   |  |  |  |  |  | MEDICAL EXAMINER   |  |  |  |  |  |  |  |  |  | EXAMINER'S NAME (TYPE OR PRINT) <b>John P. Rogers</b>   |  |                          |  |  |  |  |  |  |  | ADDRESS <b></b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Donation</b>   |  |                  |  |   |  |  |  |  |  | 23b. DATE <b>Apr. 22, 1981</b>   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Anatomical Bd.</b>   |  |                          |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN <b>Washington D.C.</b> COUNTY <b></b> STATE <b></b>               |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Columbia Mortuary Service</b> ADDRESS <b>4748 Wisc. Ave. N.W. Washington D.C.</b>  |  |                  |  |   |  |  |  |  |  | 25a. DATE DEC'D. BY REGISTRAR <b>MAY 1 1981</b>  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b></b>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

11/10/1918

11/10/1918

11/10/1918

11/10/1918

11/10/1918

11/10/1918

11/10/1918

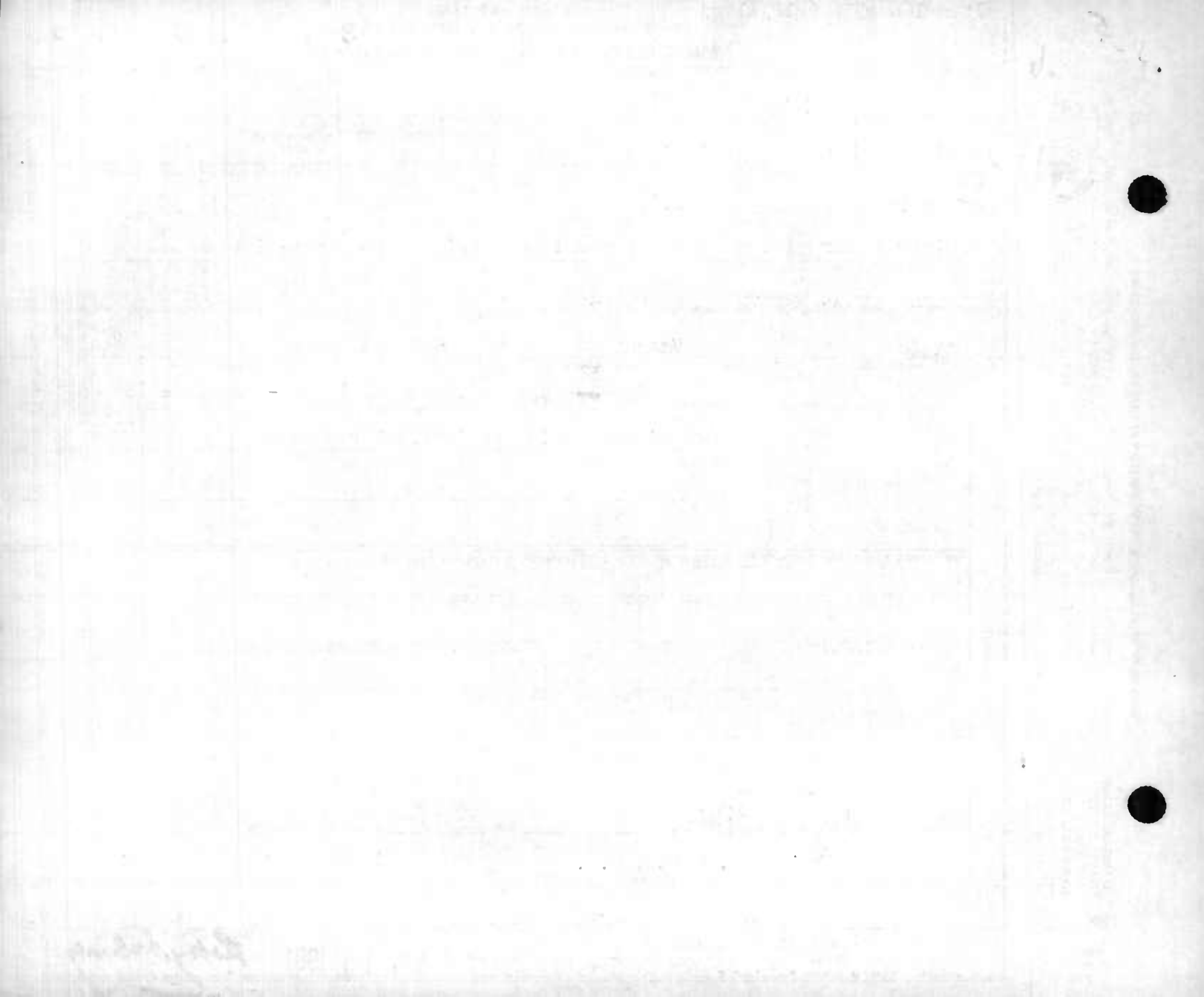
11/10/1918

11/10/1918

11/10/1918

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |  |  |   |                             |  |  |  |  | REG. NO. 10916  |  |
|---|------------------|--|--|---|-----------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Judith V. Ladas   |                  |  |  |   |                             |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>4 10 1981 |  |
| 3. SEX<br>Female  | 4. RACE<br>White | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 11, 1940  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS. | IF UNDER 1 YR. MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>4 10 1981  |  | 2d. HOUR<br>11:14 P.M.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Olney  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  |   |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                  |  |  |   |                             |  |  |  |  |   |  |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Rockville  |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4930 Bel Pre Road   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Gerald Varnum  |                  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marguerite Henly  |                             |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |                  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>150-30-1085   |                             | 17. INFORMANT ADDRESS<br>Gregory J. Ladas - Same as 13 Husband                               |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                  |  |  |   |                             |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION  |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                             |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                             |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                             |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |                  |  |  |   |                             |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>   |                  |  |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER   |                             |  |  | DATE SIGNED 4-12-81  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.   |                  |  |  | ADDRESS 111 Penn Street   |                             |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>4/15/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fairview Cemetery   |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Westfield Union N.J.                              |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS   |                  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 15 1981  |                             | 25b. REGISTRAR'S SIGNATURE<br><u>Robert Kennedy</u>  |  |  |  |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |                  |  |  |   |                             |  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8110917   |  |   |  |
|---|--|--|--|---|--|---|--|
| FOR<br>1- STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Edward LAMBERT, JR.  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 12 1981<br>2b. HOUR<br>8:15A M   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 22 1926  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Correctional Officer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>al center  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Virginia  |  |  |  | 13b. CITY OR TOWN<br>Stafford   |  | 13c. STREET ADDRESS<br>Route 2, Box 622   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Edward Lambert  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Margaret Sanger   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>1944-64   |  | 17. INFORMANT<br>Mrs. Jean Lambert See item 13  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar. 30</u> , 19 <u>81</u> , to <u>Apr. 12</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Apr. 12</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>George T. Gamblin</u> MD   |  |  |  | 22c. DATE SIGNED<br>Apr. 13 1981  |  | 22d. ADDRESS<br>National Naval Medical Center, Bethesda, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>4-14-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenwood Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Goochland County, Va.   |  |
| 24. FUNERAL DIRECTOR<br><u>J. V. Ferguson</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 16 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

BP \_\_\_\_\_

## Sincerely,

e. 7-10-80



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Chester Graham Lampert  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 20 81                                    |   | 2b. HOUR<br>1 45 A M   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 3 1909  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>7 1 YRS.                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ILLINOIS  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                            |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8500 Hempstead Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Administrator | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. GOVERNMENT  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Bethesda   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>8500 Hempstead Avenue   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmer Edwin Lampert  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine French   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II<br>215-38-3054   |   | 17. INFORMANT<br>ADDRESS<br>Emily Lampert (wife) 8500 Hempstead Ave, Bethesda, Md               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF Brain<br>1919<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mos.   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 81 to 4/20 19 81, that (I) (we) last saw the deceased alive on 4/19 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |   |   |  |
| 22b. SIGNATURE<br>R.T. Benack MD   |  |   |   | 22c. DATE SIGNED<br>4/20/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R.T. Benack MD  |  |   |   | 22e. ADDRESS<br>4115 Colie Dr. Wheaton, Md 20906  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>April 21, 1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem   |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Alexandria, Virginia  |  | 23e. COUNTY<br>Alexandria   |   | 23f. STATE<br>Virginia  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 24 1981  |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |   | 25c. REGISTRAR'S NAME<br>[Name]   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or cited.

SECRET  
NO FORN DISSEM

TOP SECRET

SECRET

TOP SECRET

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |  |  |   |  | REG. NO. 10919   |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MARJORIE  |  | MIDDLE ANN  |  | LAST LARSEN  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 6 9 85   |  | 6. AGE IN YEARS<br>YRS. 65   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 4 20 81  |  | 7d. HOUR<br>P 4:30   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mass.                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gov't.  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5301 WESTBAND -Circle |  | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor   |  | 12d. KIND OF BUSINESS OR INDUSTRY<br>Gov't.  |  | 13a. STATE<br>MD  |  | 13b. COUNTY<br>MONTGOMERY  |  |
| 13c. CITY OR TOWN<br>BETHESDA  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  | 13e. STREET ADDRESS<br>5301 WESTBAND Circle   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence E. Esters   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary A. Harrington   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No                       |  |
| 16b. SOCIAL SECURITY NO.<br>010-10-6605  |  | 17. INFORMANT<br>A. Levitt Taylor, 40 Court St., Boston   |  | 17. ADDRESS<br>%Adams & Blinn   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5712 UPPER GASTROINTESTINAL HEMORRHAGE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CIRRHOSIS WITH VARICES<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ALCOHOLISM<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>ACUTE<br>2-3 YRS<br>20 YRS |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>21b. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21c. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 4 18 81   |  | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>VOMITED BLOOD |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>5301 WESTBAND Ave. Bethesda Md. MD   |  | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  | 22b. ACTUAL SIGNATURE<br>Francis C. Mayle  |  | 22c. TITLE (SPECIFY)<br>Dept  |  | 22d. DATE SIGNED<br>4/20/81  |  |
| 22e. EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Francis C. Mayle                        |  | 22f. ADDRESS<br>8200 Wisconsin Ave Bethesda   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>4/22/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Md.                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's sons, Inc.                         |  | 24b. ADDRESS<br>5130 Wisc. Ave. N.W. Wash., D.C. 20016  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. DATE REC'D. BY REGISTRAR   |  | 25d. REGISTRAR'S SIGNATURE   |  |

APR 27 1981

SECRET

SECRET

XX

U.S.A.

W.A.S.

Govt.

Director

Circle

State

Department

Office

Section

Division

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

100-1-1000

10

100-1-1000

100-1-1000

100-1-1000

100-1-1000

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

10920

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles F. Layton, Jr.</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 15, 1981</b> |  |  | 2b HOUR<br><b>11:40pm</b>   |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 19, 1895</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>85</b> |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>    |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>Maryland Howard</b>  |  | 13c CITY OR TOWN<br><b>Woodbine</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>1775 St. Michael's Rd.</b>   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles F. Layton, Sr.</b>   |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret McSherry</b>   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-36-0913</b>   |   | 17 INFORMANT<br>ADDRESS<br><b>2732 Jennings Chapel Rd</b><br><b>Noreen Gordon Woodbine, Maryland</b>   |  |   |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Coronary insufficiency &amp; myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b><br><b>3 1/2 hrs</b> |  |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>Chronic bronchitis; chronic renal insufficiency</b>  |  |  |   |  |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Apr. 15</b> , 19 <b>81</b> , to <b>Apr. 15</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Apr. 15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |   |  |
| 22b SIGNATURE<br><b>Frederick Moomau M.D.</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c DATE SIGNED<br><b>4-15-81</b>                     |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick Moomau, M.D.</b>  |  |  |   | 22e ADDRESS<br><b>18111 Prince Phillip Dr., Olney, Md.</b>   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>4/18/81</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Jennings Chapel</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodbine Howard Md.</b>   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Olin L. Molesworth, P.A., Damascus, Md.</b>  |  |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>APR 20 1981</b>   |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

MEDICAL CERTIFICATION

35  
69  
35  
130  
2  
2  
9  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retention by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Main  
 Office  
 USA  
 Maryland  
 Howard  
 Woodbine  
 1775 St. Michael's Rd.  
 Charles W. Lanyon, Jr.  
 219-36-0513  
 1775 Tennessee Chapel Rd.  
 Woodbine, Maryland

Frederick Norman, N.O.  
 1811 Prince William Dr., Orléans, W.  
 415461  
 Tennessee Chapel  
 Woodbine Howard Rd.  
 1775 Tennessee Chapel Rd.  
 Woodbine, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 9 2 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mercedes S Lee   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 15, 1981                         |  | 2b. HOUR<br>1324 M   |
| 3 SEX<br>female   | 4 RACE<br>Caucasian   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12-24-1890  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Fla.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                 |  |
| 10 CITY OR TOWN OF DEATH<br>Gaithersburg  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None  |
| 13a. STATE<br>Maryland  |   |  | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Gaithersburg  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest O. Saltmarsh   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret E. Brent            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO<br>578-64-8380   |   | 17 INFORMANT<br>ADDRESS<br>Bethesda, Md.<br>Ernest S. Lee (son) 6816 Algonquin Ave.  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>30 years</u> |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>June 48  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>April 15, 19 81                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 48</u> to <u>April 15, 19 81</u> , that (I) (we) lost<br>saw the deceased alive on <u>April 15, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |  |   |  |  |
| 22a. SIGNATURE<br>Richard C. Burgess MD for Edwin T. Parker MD  |   |  |   | 22c. DATE SIGNED<br>4/15/81  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard C. Burgess for Edwin T. Parker   |   |  |   | 22d. ADDRESS<br>2015 R St., N.W., Wash DC 20009                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>4-21-1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Nat'l. Cem.                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Virginia  |   | 23e. DATE REC'D. BY REGISTRAR<br>APR 21 1981   |   |  |  |
| 24 FUNERAL DIRECTOR<br>DeVal Funeral Home, Inc.<br>2222 Wisc. Ave. N.W. D.C.  |   | 25b. REGISTRAR'S SIGNATURE   |   |  |  |

BP



|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |     |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 | 105 | 106 | 107 | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 | 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 | 136 | 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 | 145 | 146 | 147 | 148 | 149 | 150 | 151 | 152 | 153 | 154 | 155 | 156 | 157 | 158 | 159 | 160 | 161 | 162 | 163 | 164 | 165 | 166 | 167 | 168 | 169 | 170 | 171 | 172 | 173 | 174 | 175 | 176 | 177 | 178 | 179 | 180 | 181 | 182 | 183 | 184 | 185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 | 1488 | 1489 | 1490 | 1491 | 1492 | 1493 | 1494 | 1495 | 149 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|-----|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |   |   |   |   |  |
|---|--|--|---|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | 8 1 1 0 9 2 2   |   |   |   |  |
| CERTIFICATE OF DEATH  |  |  |   |   | REG. NO.  |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>TILGHMAN NMN LEE</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>04 30 81</b>                               |   |   | 2b. HOUR<br><b>100 A M</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 21 93</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                 |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD.</b>                     |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>MONTG.</b> 13c. CITY OR TOWN <b>Poolesville</b>   |  |  |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>14700 Sugarland Lane.</b>                   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>SAMUEL LEE</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARTHA HARPER</b>                |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>214-18-8315</b>                                    |   | 17. INFORMANT ADDRESS<br><b>Bessie Lee (wife) Same AS #13</b>         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>massive pulmonary embolism</b><br>4151<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>—</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> |  |  |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)<br><b>Carcinoma of prostate</b>  |  |  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-17-1981</b> to <b>4-29-1981</b> , that (I) (we) lost saw the deceased alive on <b>4-29-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |   |   |  |
| 22b. SIGNATURE <b>H. Bahar</b>  |  |  |   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>4-30-81</b>                                    |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Bahar, M.D.</b>  |  |  |   |   | 22e. ADDRESS<br><b>8218 Wisconsin Ave, Bethesda, Md.</b>                          |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>MAY 5, 1981</b>                                     |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul Cem.</b>                        |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Sugarland Montg MD.</b> |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>George R. Snowden</b>   |  |  | 24b. ADDRESS<br><b>246 N. WASH. ST. Rockville, Md.</b>              |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1981</b>                                 |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                      |   |  |

MAY 6 1981

1321

K

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 10923   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE JOSEPH LEGNER</b>   |  |  |  |  |  |  |  |  |  | 2b. DATE KNOWN OF DEATH <b>April 23, 1981</b>                                      |  |
| 3. SEX <b>M</b> 4. RACE <b>W</b> 5. DATE OF BIRTH <b>Sept 22, 1960</b> 6. AGE (IN YEARS) <b>20</b> YRS. 7c. DATE PRONOUNCED DEAD <b>April 23, 1981</b>   |  |  |  |  |  |  |  |  |  | 7b. HOUR <b>11:00 A.M.</b> 7d. HOUR <b>11:00 A.M.</b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>                             |  |
| 10. CITY OR TOWN OF DEATH <b>Olney</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>General Harry</b>  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plant Manager</b> |  |
| 13a. STATE <b>VA</b> 13b. COUNTY <b>Loudoun</b> 13c. CITY OR TOWN <b>Round Hill</b> 13d. INSIDE CITY LIMITS? <b>YES</b> 13e. STREET ADDRESS <b>Route 1 - Box 129 22141</b>   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>                                 |  |
| 14. FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b>(Unk.)</b> LAST <b>Legner</b> 15. MOTHER'S MAIDEN NAME FIRST <b>Edith</b> MIDDLE <b>(Unk.)</b> LAST <b>Gehl</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b> 16b. SOCIAL SECURITY NO. <b>037-20-3876</b> 17. INFORMANT <b>Harry L. Legner</b>   |  |  |  |  |  |  |  |  |  | 17. ADDRESS <b>216 Camelot Circle Richmond, VA 23229</b>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? <b>NO</b>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>[Signature]</b> TITLE (SPECIFY) <b>Medical Examiner</b> MEDICAL EXAMINER   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>April 23, 1981</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>4-26-1981</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bluemont Loudoun VA</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>David J. Soule</b> ADDRESS <b>Hall Fun. Home Purcellville, VA 22132</b> 25a. DATE DEPT. BY REGISTRAR <b>APR 28 1981</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |  |  |  |  |  |  |  |  |  |

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 9 2 4

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | April 1 1981   |  | 1200 Noon  |  |
| Stanley J. LENARSKI  |  |  |  |  |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  |
| Male   |  | Caucasian  |  | MONTH DAY YEAR   |  | 72 YRS.  |  |
| Aug. 20 1908   |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |
| New Jersey   |  | USA  |  |  |  | Montgomery MD.   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda   |  | National Naval Medical Center,   |  | U. S. Navy   |  | U.S. Gov't,  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |
| 13a. STATE   |  | Middlesex  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 108 Clay Street  |  |
| N. J.  |  |  |  |  |  |  |  |
| 14 FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |  |  |
| Joseph Lenarski  |  | Rose Prusik  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT   |  | ADDRESS  |  |
| Yes  |  | WWII   |  | 220 26 7084  |  | Charlotte Christensen See item 13                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 18b. SOCIAL SECURITY NO.   |  | 17 INFORMANT   |  | ADDRESS  |  |
| PART I. DEATH WAS CAUSED BY:   |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| IMMEDIATE CAUSE (a)  |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| 1991   |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| (b)  |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| (c)  |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  | 220 26 7084  |  | Charlotte Christensen See item 13  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Mar. 15, 1981, to Apr. 1, 1981, that (I) (we) lost saw the deceased alive on Apr. 1, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|  |  | MARIE D. BROWNING  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | Apr. 1, 1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |
| MARIE D. BROWNING  |  | National Naval Medical Center, Bethesda, Md.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Burial   |  | 4-4-81   |  | Holy Cross Cemetery  |  | Hamilton Township, N.J. COUNTY STATE                           |  |
| 24 FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| James E. D. Brown  |  | APR 6 1981   |  |  |  |  |  |
| DeVol Funeral Home   |  |  |  |  |  |  |  |
| Washington, D.C.   |  |  |  |  |  |  |  |



X



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1111.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                     |   |
|---|--|---|---|---|---------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY P. LENZ |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 7, 1981 |   | 2b. HOUR<br>9:15 PM |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 28, 1911  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>District of Col.         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4940 Sentinal Dr. Apt. 403 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Montgomery   |   | 13c. CITY OR TOWN<br>Bethesda   |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>David C. Poore                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Benva Herbert   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |                     |   |
| 16b. SOCIAL SECURITY NO.<br>578-03-6480                               |  | 17. INFORMANT ADDRESS<br>Ralph M. Lenz Same as Item # 13  |   |   |                     |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Malignant melanoma-metastatic</u><br>1729<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 1/2 yrs.</u> |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
Chronic lymphocytic leukemia.

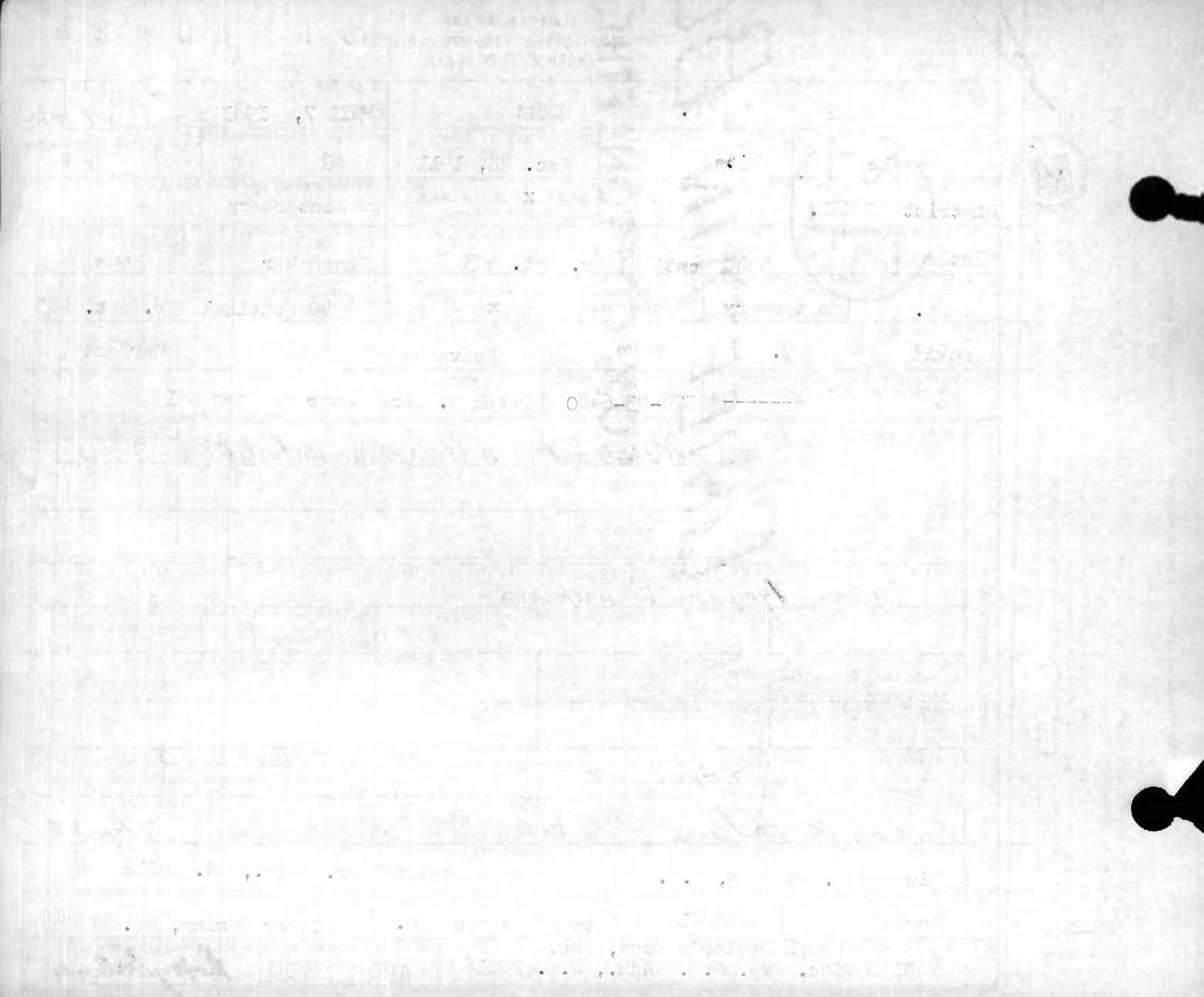
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |

22a. I certify that (I) (this hospital) attended the deceased from 2 April, 19 81, to 7 April, 19 81, that (I) (we) last saw the deceased alive on 2 April, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 22b. SIGNATURE<br><u>Richard M. Huffman</u>                       |  | DEGREE<br>M.D.                                     |  | 22c. DATE SIGNED<br>7 April 81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard M. Huffman, M.D. |  | 22e. ADDRESS<br>4940 Sentinal Dr. Beth., Md. 20016 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |

|  |  |                      |  |   |  |  |  |
|--|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>4/10/81 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Md. |  |
|--|--|----------------------|--|---|--|--|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons, Inc.<br>5130 Wisc. Ave. N.W. Wash., D.C. 20016 |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1981 |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |
|--|--|--|--|--|--|



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

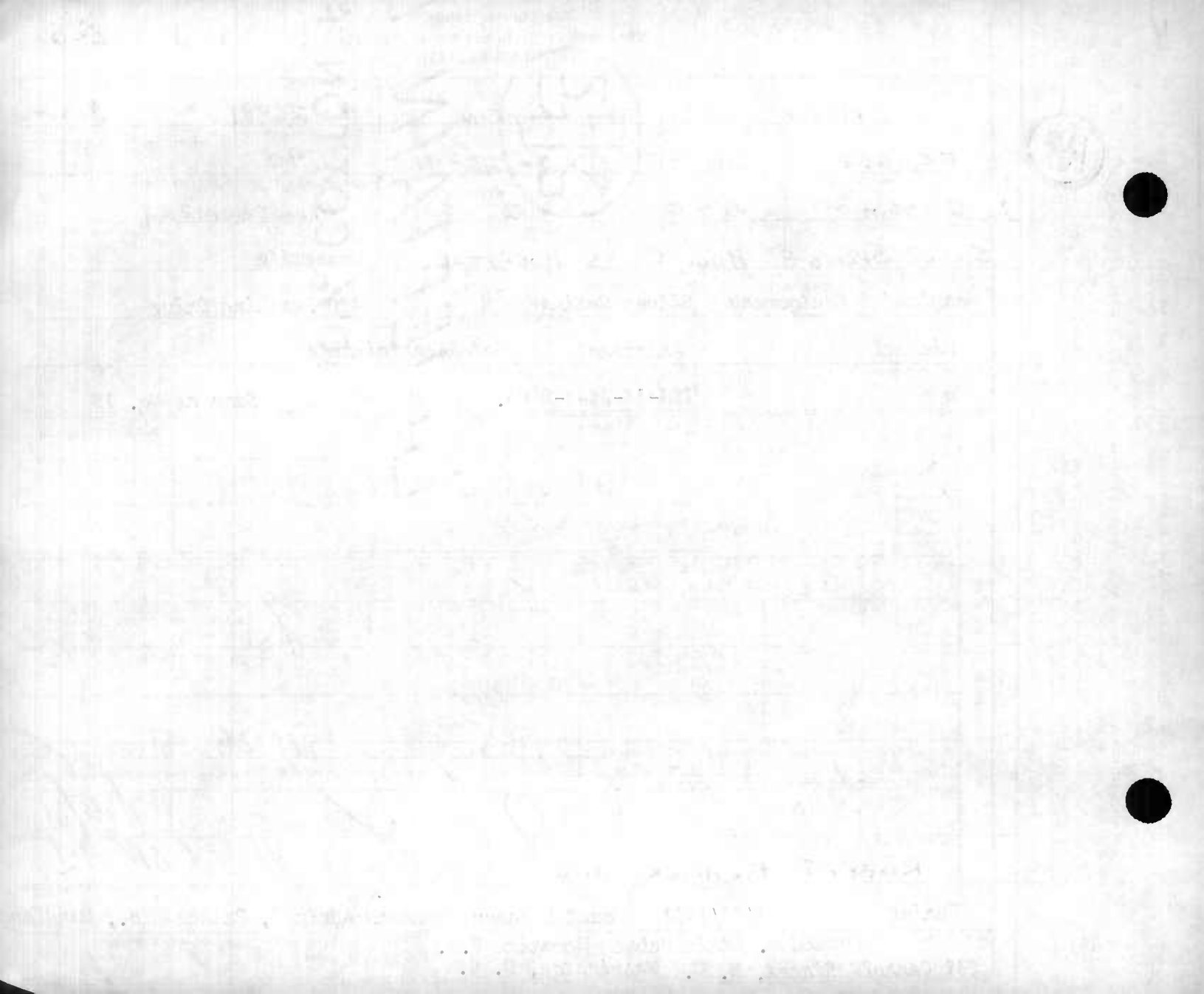
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |  |   |  |  |  |
|--|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARIA LEVITIN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-26-81</b>   |   | 2b. HOUR<br><b>8:30 A.M.</b>   |  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-28-91</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                        |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>420 Pershing Drive</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Arlozorof</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not Ascertainable</b>   |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>124-18-6248-D</b>  |   | 17. ADDRESS<br><b>Dr. George Levitine Same as No. 13</b>                             |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4148</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Ischemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>acute cholecystitis</b>  |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> 19 <b>APR 26</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4-26-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (we do not) view the body after death.  |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Kramer M.D.</b>  |  |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22d. DATE SIGNED<br><b>4/26/81</b>   |   |  |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT KRAMER M.D.</b>   |  |   | 22f. ADDRESS<br><b>8030 FENNER ST S.C. 810 ND</b>   |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>4/28/1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Lebanon Cemetery</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Adelphi, Prince Geo., Maryland</b>             |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Donald M. Stein Hebrew Memorial F.H.</b>   |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>APR 30 1981</b>  |   |  | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                      |   |  |  |  |
| 232 Carroll Street, N. W. Washington, D. C.  |  |   |   |   |  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 0 9 2 7   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| LIZZA LIBRETT   |  |  |  | 4/1/81 6:55 AM  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female  |  | White  |  | Feb. 8, 1892  |  | 89 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Russia  |  | USA  |  |   |  | MONTGOMERY MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| ROCKVILLE   |  | Hebrew Home of Greater Wash.   |  | Dressmaker (Ret)  |  | Self Emp.  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Maryland  |  |  |  | Montgomery  |  | Sil. Spg.  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| Harry   |  |  |  | Esther  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| No  |  |  |  | 104-18-9315   |  | A Harriet Males; 6404 Tone Dr, Beth.Mc                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST -</u>  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTICEMIA.</u>   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASPIRATION PNEUMONITIS.</u>   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> 19 <u>80</u> to <u>4/1/81</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4/1/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| H. D. Khianey   |  |  |  |   |  | 4/1/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |
| HIRSH. D. KHIANEY   |  |  |  | HEBREW HOME OF WASH. D.C.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 4-3-81   |  | Nat'l. Mem. Park  |  | Falls Church, Virginia   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. BY REGISTER  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike   |  |  |  | Rockville, Md.  |  |  |  |

H 111111

LIZ A RIKETT

WHIGOMERY

ROCKVILLE

111111



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAY B. LICHTENBERG</b>                |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>4 5 81</b> |   |  | 2b. HOUR <b>2:35</b> M   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 17, 1930</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>                 |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>                          |  |   |  |   |  |  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS <b>9008 Quintana Drive</b>                               |  |   |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Irving Lichtenberg</b>                |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Small</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> |  | 16b. SOCIAL SECURITY NO. <b>576-30-4385</b>   |  | 17. INFORMANT ADDRESS <b>Bethesda, Md.</b>  |  |  |  |
|  |  | <b>Korean</b>   |  | <b>Cathy Lichtenberg; 9008 Quintana Dr.</b>   |  |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>YEARS</b>       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CEREBRAL THROMBOSIS; MULTIPLE FOLLOWS EYE</b>  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK NOT WHITE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-5</b> 19 <b>81</b> , to <b>4-5</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4-5</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE <b>Irwin H. Arday</b>  |  | DEGREE <b>M.D.</b>  |  | 22c. DATE SIGNED <b>4-5-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRWIN H. ARDAY</b>   |  | 22e. ADDRESS <b>5454 WISCONSIN AVE WASH. D.C. 20014</b>             |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>4-7-1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Judean Memorial Gardens</b>                 |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Maryland</b>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Larry W. Reich</b> ADDRESS <b>Danzanski - Goldberg</b> DATE REC'D. BY REGISTRAR <b>APR 9 1981</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





RECEIVED BY MAIL

RECEIVED BY MAIL

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Franklin G. Liming</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 7, 1981</b>              |  | 2b. HOUR<br>MIN.<br><b>9:08AM</b>                   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT 29, 1904</b>                       |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>76</b>                |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                  |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RESEARCH FORESTER</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT OF AGRICULTURE</b>          |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. CITY OR TOWN<br><b>SILVER SPRING</b>                                |  | 13c. STREET ADDRESS<br><b>3486 GLENEAGLES DRIVE</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ORA LEE LIMING</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PEARL EARHART</b>     |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>224-60-3042</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>NAOMI E. LIMING SAME AS 13 WIFE</b>              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>1b) <b>Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>1c) <b>Ischemic cardiomyopathy</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> , 19 <b>81</b> , to <b>4/7</b> , 19 <b>81</b> , that (I, we) last saw the deceased alive on <b>4/7/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>A. Rotztein</b>  |  |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. ROTZTEIN</b>   |  |   | 22e. ADDRESS<br><b>3701 Rossmore Blvd.<br/>Silver Spring, M.D. 20906</b> |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>4/8/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREMATORY</b>            |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 08 1981</b>   |  | 25b. ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, M.D. 20901</b>          |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ALEXANDRIA VIRGINIA</b>  |  |   |  |  |   |  |

MEDICAL CERTIFICATION



1901-1904

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 0 9 3 0  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>LURINDA J. LLEWELLYN</b>   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>April 16, 1981</b>   |  | 2b HOUR<br><b>3:40A M</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Oct 17 1987</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>93</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebraska</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Sandy Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Friends Nursing Home</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 13a STATE<br><b>MD</b>   |  | 13b COUNTY<br><b>Mont</b>   |  | 13c CITY OR TOWN<br><b>Rockville</b>   |  | 13d STREET ADDRESS<br><b>16305 Emory Lane</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles H. Babcock</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Delissa P. Dunafon</b>   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>217-52-9798</b>   |  | 17 INFORMANT ADDRESS<br><b>Lillian J. Zuck (Same as 13e)</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Obstructive Pulmonary Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks</b><br><b>2 mo.</b><br><b>4 years</b> |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>4/3 74</b> <b>4/16 81</b>  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3/3/81</b> to <b>4/16/81</b> , that (I) (we) last saw the deceased alive on <b>4/16/81</b> above. (If not, I did not view the body after death.)  |  |   |  |  |  |  |  |
| 22b SIGNATURE <b>[Signature]</b>   |  |   |  | DEGREE   |  | 22c DATE SIGNED <b>4/16/81</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. H. Ligon</b>   |  |   |  | 22e ADDRESS<br><b>18111 Pk Philip Dr, Olney MD 20832</b>   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>April 20, 1981</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Et. Lincoln Cemetery</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Bladensburg Maryland</b>  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey</b>  |  |   |  | 25a DATE OF DEATH BY REGISTRATION<br><b>APR 24 1981</b>  |  |  |  |
| 24b ADDRESS<br><b>P.A., Rockville, Maryland</b>  |  |   |  | 25b REGISTRAR SIGNATURE<br><b>[Signature]</b>  |  |  |  |

April 15, 1981 3:40

18305 Emory Lane

Rockville

Mont

MD

Handwritten signature

APR 25 1981

211-1112

5000  
BPDHMH-16 30M 2/80  
(VRA 15, 4)

Released by Medical Examiner's Office after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |   |  |
| REG. NO. 1 0 9 3 1   |  |   |  |  |   |  |  |   |  |
| 1. FOR STATE REGISTRAR   |  |   |  |  |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LENNA B. LOCHTE</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>April 19 81</b> 2b. HOUR <b>6:50 PM</b> |  |  |   |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>June 5, 1885</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b> IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |   |  |  |   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Bethesda</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>4703 Glenbrook Parkway</b>                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Hanson M. Cronise</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Brubaker</b>            |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-14-3203</b>   |  | 17. INFORMANT ADDRESS <b>Helen L. Tinsley, Rockville, Maryland</b>   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b> |  |   |  |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>SEVERITY</b>   |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  |  |   |  |  |   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |  |   |  |  |   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |   |  |  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |   |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  |  |   |  |  |   |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  |   |  |  |   |  |  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  |  |   |  |  |   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NOV 80</b>  |  |   |  |  |   |  |  |   |  |
| 21f. LOCATION CITY OR TOWN COUNTY STATE <b>4/19 81</b>   |  |   |  |  |   |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on <b>April 19 81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.       |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE DEGREE <b>Thos G. Ward</b>  |  |   |  |  |   |  |  |   |  |
| 22c. DATE SIGNED <b>4/19/81</b>  |  |   |  |  |   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. Ward</b>  |  |   |  |  |   |  |  |   |  |
| 22e. ADDRESS <b>6116 Robin Hood, Bethesda, Md 20034</b>  |  |   |  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |   |  |  |   |  |  |   |  |
| 23b. DATE <b>23, 1981</b>  |  |   |  |  |   |  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>  |  |   |  |  |   |  |  |   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Maryland</b>  |  |   |  |  |   |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Robert A. Pumpfrey Funeral Homes, P.A., Bethesda, Maryland</b>   |  |   |  |  |   |  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR <b>APR 27 1981</b>   |  |   |  |  |   |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Walter R. Brubaker</b>   |  |   |  |  |   |  |  |   |  |

(M)

1. 10/17/1943  
10-17-43

10-17-43  
10-17-43  
10-17-43

10-17-43  
10-17-43  
10-17-43

10-17-43  
10-17-43  
10-17-43

10-17-43  
10-17-43  
10-17-43



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |  |   |  |  |  |
|---|--|--|--|---|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGUERITE S. LYMAN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04/06/1981</b> |   |   | 2b. HOUR<br>MIN.<br><b>11:58 PM</b>  |   |  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-13-88</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                        |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Rockville, MONTGOMERY MD</b>              |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                                     |   |  |  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>Mt. Garry</b>                          |   | 13c. CITY OR TOWN<br><b>Gaith</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>600 W Deer Park Rd.</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HAROLD SERRELL</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA HETFIELD</b>   |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>064-12-9071</b>           |   | 17. INFORMANT<br>ADDRESS<br><b>DAUGHTER - MARJORIE L. LAINE SAME AS #13</b> |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia Respiratory Failure</b><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b> |  |  |  |   |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |  |  |   |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/28/81</b> 19 <b>81</b> to <b>4/6/81</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>4/6/81</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gawin L. Flynn MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |   | 22c. DATE SIGNED<br><b>4/7/81</b>  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GAWIN L. FLYNN MD</b>   |  |  |  | 22e. ADDRESS<br><b>9901 Medical Center Drive</b>  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>4-10-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLSIDE CEM.</b>                           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PLAINFIELD N.J.</b>                 |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>DEVAL FUNERAL HOME WASHINGTON, D.C.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1981</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. K. K. K.</b>                                  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



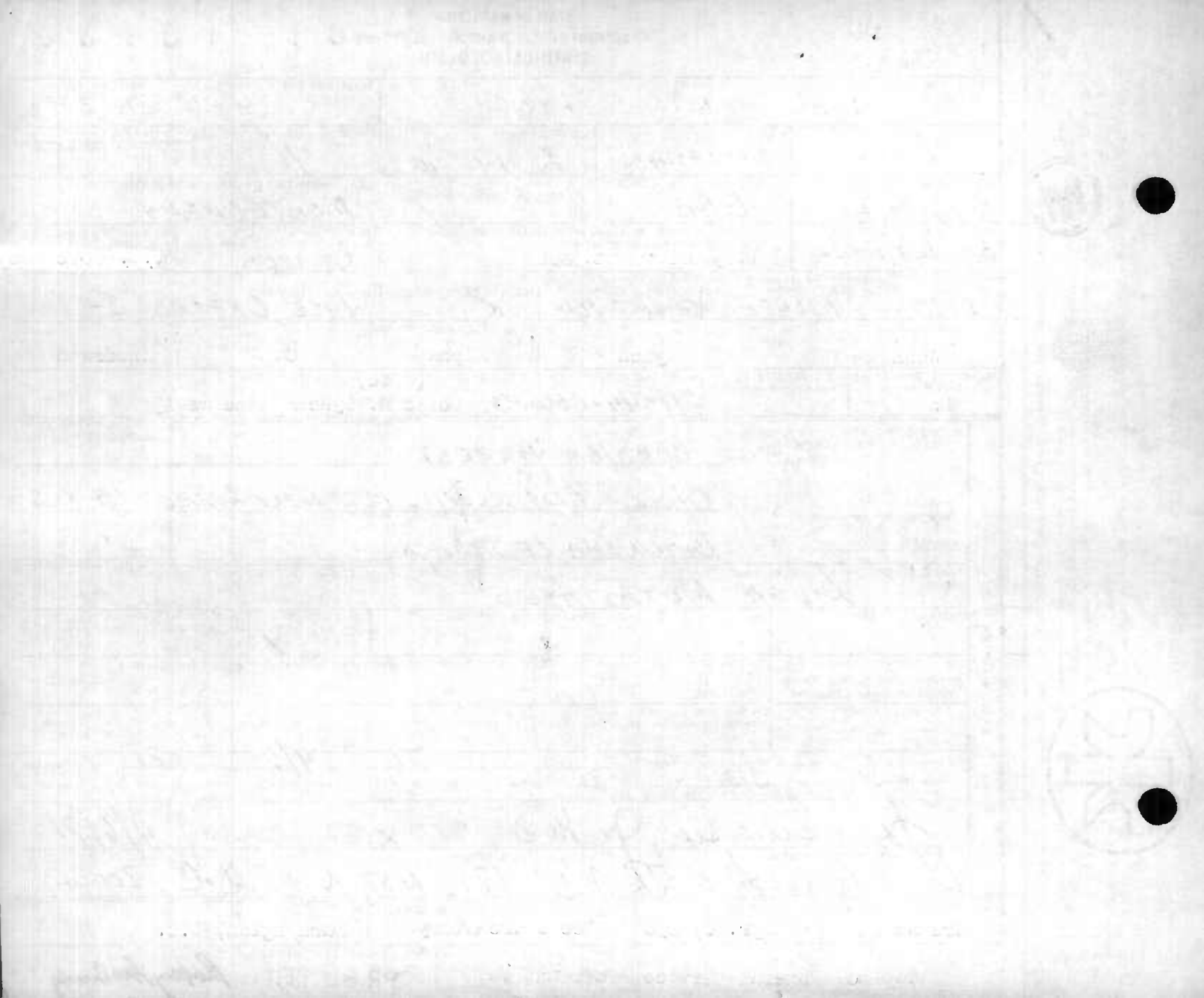
APR 10 1981  
Library

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |              |   |   |  |                              |   |                                   | 8 1 1 0 9 3 3  |  |
|--|--|---|--------------|---|---|--|------------------------------|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |   |              |   | REG. NO.  |  |                              |   |                                   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |              |   | 2a. DATE OF DEATH   |  |                              |   |                                   | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>JOHN M. LYNCH   |  |   |              |   | MONTH DAY YEAR<br>4 6 81  |  |                              |   |                                   | 3 30 AM  |  |
| 3. SEX   |  | 4. RACE   |              | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                              |   | 7. IF UNDER 1 YEAR                |  |  |
| MALE   |  | CAUCASIAN   |              | MONTH DAY YEAR<br>2 14 10   |   | 71 YRS.  |                              |   | IF UNDER 24 HRS.                  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                              |   |                                   |  |  |
| CHICAGO, ILL.  |  | USA   |              |   |   | MONTGOMERY MD.   |                              |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |              |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                              |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| GARRETT PARK   |  | 4405 Oxford Street  |              |   |   | RETIRED  |                              |   | U.S. Gov't.                       |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |              |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS          |   |                                   |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>MD. MONT. GARRETT PARK   |  |   |              |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4405 OXFORD ST.              |   |                                   |  |  |
| 14. FATHER'S NAME  |  |   |              |   | 15. MOTHER'S MAIDEN NAME  |  |                              |   |                                   |  |  |
| FIRST MIDDLE LAST<br>John Lynch  |  |   |              |   | FIRST MIDDLE LAST<br>Alpha G. Anderson                              |  |                              |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |              |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT (wife) ADDRESS |   |                                   |  |  |
| No   |  |   |              |   | 217-44-0632-M   |  | Doris D. Lynch Same as 13    |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |              |   |   |  |                              |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) CARDIAC ARREST   |  |   |              |   |   |  |                              |   |                                   |  |  |
| 4960 DUE TO, OR AS A CONSEQUENCE OF  |  |   |              |   |   |  |                              |   |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 15 YRS  |  |   |              |   |   |  |                              |   |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF STOMACH  |  |   |              |   |   |  |                              |   |                                   | 5 YRS.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |              |   |   |  |                              |   |                                   |  |  |
| LIVER METASTASES   |  |   |              |   |   |  |                              |   |                                   |  |  |
| 19a. DATE OF OPERATION   |  |   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |                              | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |              |   |   |  |                              | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                              |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                              |   |                                   |  |  |
|  |  |   |              |   |   |  |                              |   |                                   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 71 to 4/6 19 81, that (1) (we) lost saw the deceased alive on 3/31 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |              |   |   |  |                              |   |                                   |  |  |
| 22b. SIGNATURE   |  |   |              | DEGREE  |   |  |                              | 22c. DATE SIGNED  |                                   |  |  |
| Louis Gillespie, Jr. M.D.  |  |   |              | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |  |                              | 4/6/81  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |              | 22e. ADDRESS  |   |  |                              |   |                                   |  |  |
| LOUIS GILLESPIE, JR. M.D.  |  |   |              | 1716 N ST. N.W., D.C. 20036   |   |  |                              |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 23b. DATE    |   | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                   |  |  |
| Cremation  |  |   | Apr. 6, 1981 |   | Lee's Crematory   |  |                              | Washington, D.C.  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |              | ADDRESS   |   |  |                              | 25a. DATE REC'D. BY REGISTRAR                                       |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Capitol Funeral Service  |  |   |              | Fairfax, Va.  |   |  |                              | APR 08 1981   |                                   | [Signature]  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|   |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|--|--|---|--|--|--|-------------------------|--|
| Items 18b. Film#G556<br>1- FOR STATE REGISTRAR 6-29-81 al<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | REG. NO. 8 1 1 0 9 3 4  |  |  |  |  |  |   |  |  |  |                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LESTER NMN Lynn, Jr.  |  |  |  |   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-5-81  |  |  |  |  |  |   |  |  |  | 2b. HOUR MIN<br>8:05 PM |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>white   |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 28 1913  |  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>67 YRS.                             |   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 14 HRS. HOURS MIN. |  |  |  |   |  |  |  |                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                   |   |  |  |  |  |  |   |  |  |  |                         |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma PK, Md.   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hosp. |   |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Painter               |  |  |  |   |  |  |  |                         |  |
| 13a. STATE<br>Maryland  |  |  |  |   |  |   |  |   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Sil. Spring                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>512 Sterling Avenue, |  |  |  |                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Lester nmN Lynn, Sr.   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Strother |   |  |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>WW 11                                |   | 17. INFORMATION (daughter) 11724 S. Laurel Dr.,<br>Lois Pressley-Laurel, Md. 20811 |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Liver Failure<br>1850<br>DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Prostate Cancer<br>(c)  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 weeks<br>1 year   |  |  |  |  |  |   |  |  |  |                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Metastatic Carcinoma of Prostate  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |   |  |  |  |                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 17 Feb 81, 19 81, to 5 April 19 81, that (I) (we) lost saw the deceased alive on 3 April 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death. |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 22b. SIGNATURE<br>Thomas A. Benninger   |  |  |  | DEGREE MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>4/6/81  |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas A. Benninger  |  |  |  | 22e. ADDRESS<br>2676 North Hampshire Ave Longley Park Md 20703  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>4-9-1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cheltenham Georges Md.   |  |  |  |  |  |   |  |  |  |                         |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.   |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |
| 25. DATE RECEIVED BY REGISTRAR 25 APR 13 1981 REGISTRAR'S SIGNATURE   |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |                         |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the Baltimore Dept. of Health and Mental Hygiene for burial, cremation, or removal.

INVESTIGATOR: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Medical Examiner

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 1 10935<br>REG. NO.                       |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JAMES F. MAHONEY  |  |  |  |   | 2a. DATE OF DEATH<br>4-16-81                |  |  | 2b. HOUR<br>1:20 AM  |  |
| SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>4-27-00   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>SUBURBAN HOSPITAL |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lumber Co.  |  |
| 13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Maryland  |  |  |  |   | 13b. CITY OR TOWN<br>Potomac                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>Thomas   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>Margaret Powers |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WWI                  |  | 17. INFORMANT ADDRESS<br>Winifred O'Donnell, Niece. Same as item 13.  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>years</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 YRS.</u> |  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Chronic Obstructive Pulmonary Disease, Diabetes Mellitus</u>   |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept</u> 19 <u>80</u> , to <u>April 16</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>April 15</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                           |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Dwight E. Delawter M.D.</u>  |  |  |  | DEGREE  |   | 22c. DATE SIGNED<br><u>April 16, 81</u>                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dwight E. Delawter M.D.</u>   |  |  |  | 22e. ADDRESS<br><u>5500 Friendship and Chay Chase md</u>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial/Removal</u>  |  | 23b. DATE<br><u>4/17/81</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Bonaventure Cemetery</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Allegany New York</u>     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Joseph Gawler's Sons Inc</u><br>ADDRESS <u>5130 Wisc. Ave., N.W. Wash., D.C.</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 20 1981</u>   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |  |



U. S. DEPARTMENT OF AGRICULTURE

Office of the Chief of Bureau

Washington, D. C.

Report of the Chief of Bureau

for the year ending June 30, 1911

Submitted to the Board of Directors

of the United States

Department of Agriculture

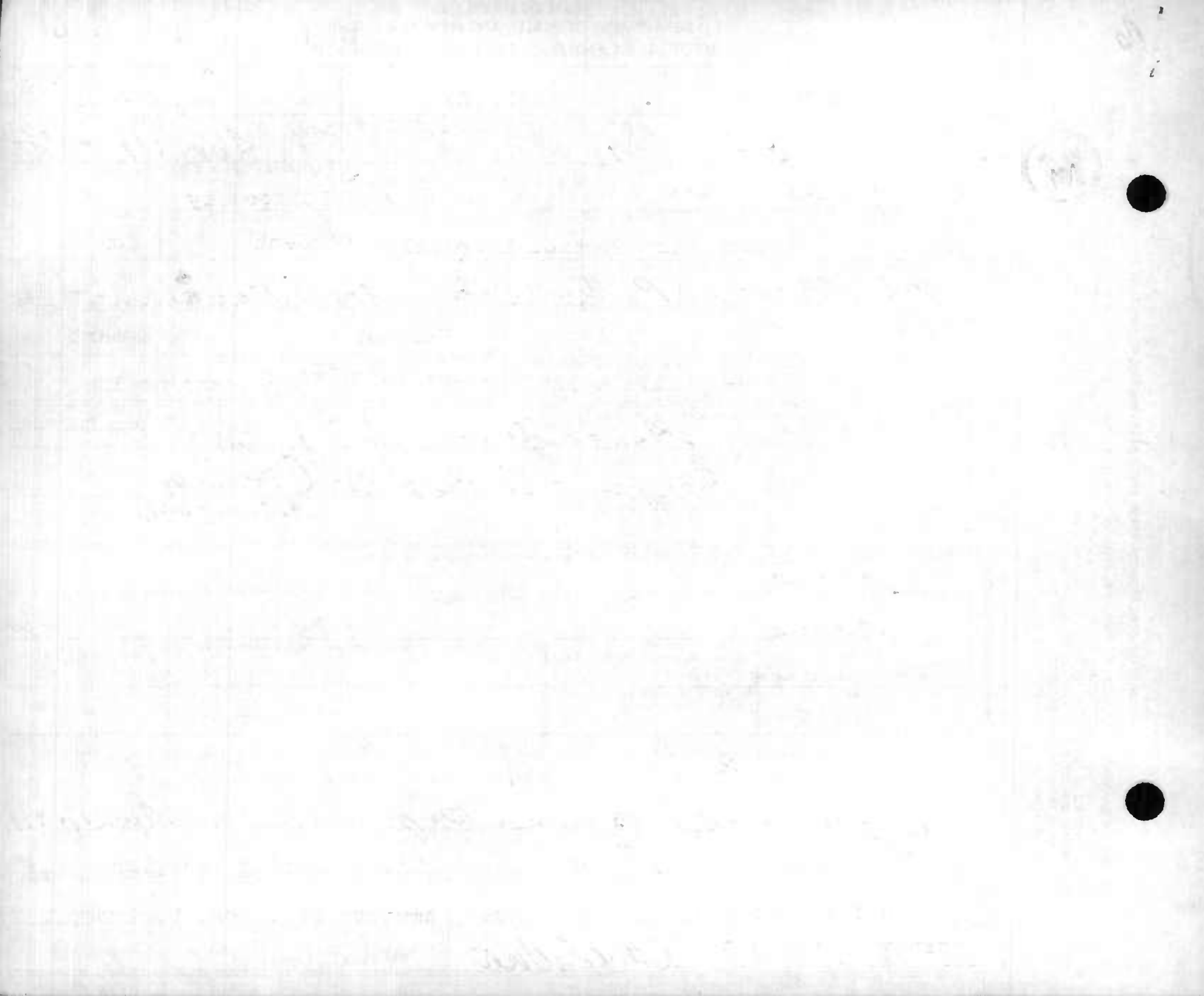
for the year ending June 30, 1911

Submitted to the Board of Directors

of the United States Department of Agriculture

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |  |                             |  |  |   |  | REG. NO. 10936 |  |
|--|------------------|--|--|--|-----------------------------|--|--|---|--|----------------|--|
| 1. FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT) <b>STEVEN W. MALLORY</b>   |                  |  |  |  |                             | 2a. DATE KNOWN OF DEATH <b>April 18, 81</b>  |  | 2b. HOUR <b>12:31 a.m.</b>                      |  |                |  |
| 3. SEX <b>M</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>Sept 1 1918</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62 YRS.</b> | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD <b>April 18, 81</b>   |  | 7d. HOUR <b>12:31 a.m.</b>                      |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>                                       |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Olney</b>   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b> |  |  |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>School</b> |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |  |  |                             |  |  |   |  |                |  |
| 13a. STATE <b>MD</b>   |                  | 13b. COUNTY <b>Mont</b>  |  | 13c. CITY OR TOWN <b>Rockville</b>   |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>4901 Blue Bonnet Ct</b>  |  |                |  |
| 14. FATHER'S NAME <b>Whitfield</b>   |                  |  |  | 15. MOTHER'S MAIDEN NAME <b>Eleanor Emmart</b>   |                             |  |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>   |                  |  |  | 16b. SOCIAL SECURITY NO. <b>217-80-1263</b>  |                             | 17. INFORMANT (father) ADDRESS <b>Whitfield Mallory-(same as 13e)</b>                        |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>7450</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) <b>Congenital Heart Dis (Truncus Arteriosus)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____               |                  |  |  |  |                             |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |                  |  |  |  |                             |  |  |   |  |                |  |
| 19a. DATE OF OPERATION <b>None</b>   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |                             | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                             |  |  |   |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                             |  |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |  |                             |  |  |   |  |                |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |                  | TITLE (SPECIFY) <b>Dep.</b>  |  |  |                             | MEDICAL EXAMINER   |  | DATE SIGNED <b>April 18, 1981</b>               |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>   |                  | ADDRESS <b>Silver Spring, Maryland</b>   |  |  |                             |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                  | 23b. DATE <b>4-21-1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Sil. Spr.</b>  |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Montgomery Md</b>                                 |  |   |  |                |  |
| 24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>   |                  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 22 1981</b>   |                             | 25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>   |  |   |  |                |  |
| 8434 Ga. Ave., S.S. Md   |                  |  |  |  |                             |  |  |   |  |                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |   |   |
|---|--|--|---|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR  |  |  |   |   | REG. NO.   |   |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Hubert K. Martin</i>   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>4-3-81</i>  |   |  | 2b. HOUR<br><i>10p M</i>  |   |
| 3. SEX<br><i>Male.</i>  |  | 4. RACE<br><i>White.</i>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Oct. 23.1889</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><i>91</i>                                  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>India.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery.</i> MD                     |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hosp</i> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Minister, Retired.</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br><i>Maryland. Prince Georges. Adelphia</i>   |  |  |   |   | 13b. STREET ADDRESS<br><i>2404 Mistletoe Pl.</i>   |   | 13c. STREET ADDRESS  |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Thomas Martin.</i>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Alice Knight.</i>                         |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br><i>No.</i>  |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><i>570-48-1294</i>   |   | 17. INFORMANT ADDRESS<br><i>Gladys Martin (Wife) (13 e)</i>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia extensive</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Organic Brain syndrome</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4/1/81</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)              |   |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December 19 79</i> , to <i>4/3/81</i> , 19____, that (I) (we) last saw the deceased alive on <i>4/3/81</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |   |   |  |   |  |   |   |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |  |   |   | DEGREE<br><i>MD</i>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>4/4/81</i>                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>OSOTH LEKAGUL MD</i>  |  |  |   |   | 22e. ADDRESS<br><i>7425 Arlington Rd Beltsville MD</i>                                     |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial.</i>   |  |  | 23b. DATE<br><i>Apr. 7, 1981</i>                                    |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>George Washington</i>                             |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Riggs Rd. P. Geo. Md.</i>  |   |   |
| 24. FUNERAL DIRECTOR<br><i>Takoma Funeral Home Inc.</i>   |  |  |   |   | DATE REC'D. BY REGISTRAR<br><i>APR 8 1981</i>  |   |  |   |   |
| 25. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |   |   |

NAME: [illegible]  
DATE: [illegible]  
FAMILY: [illegible]

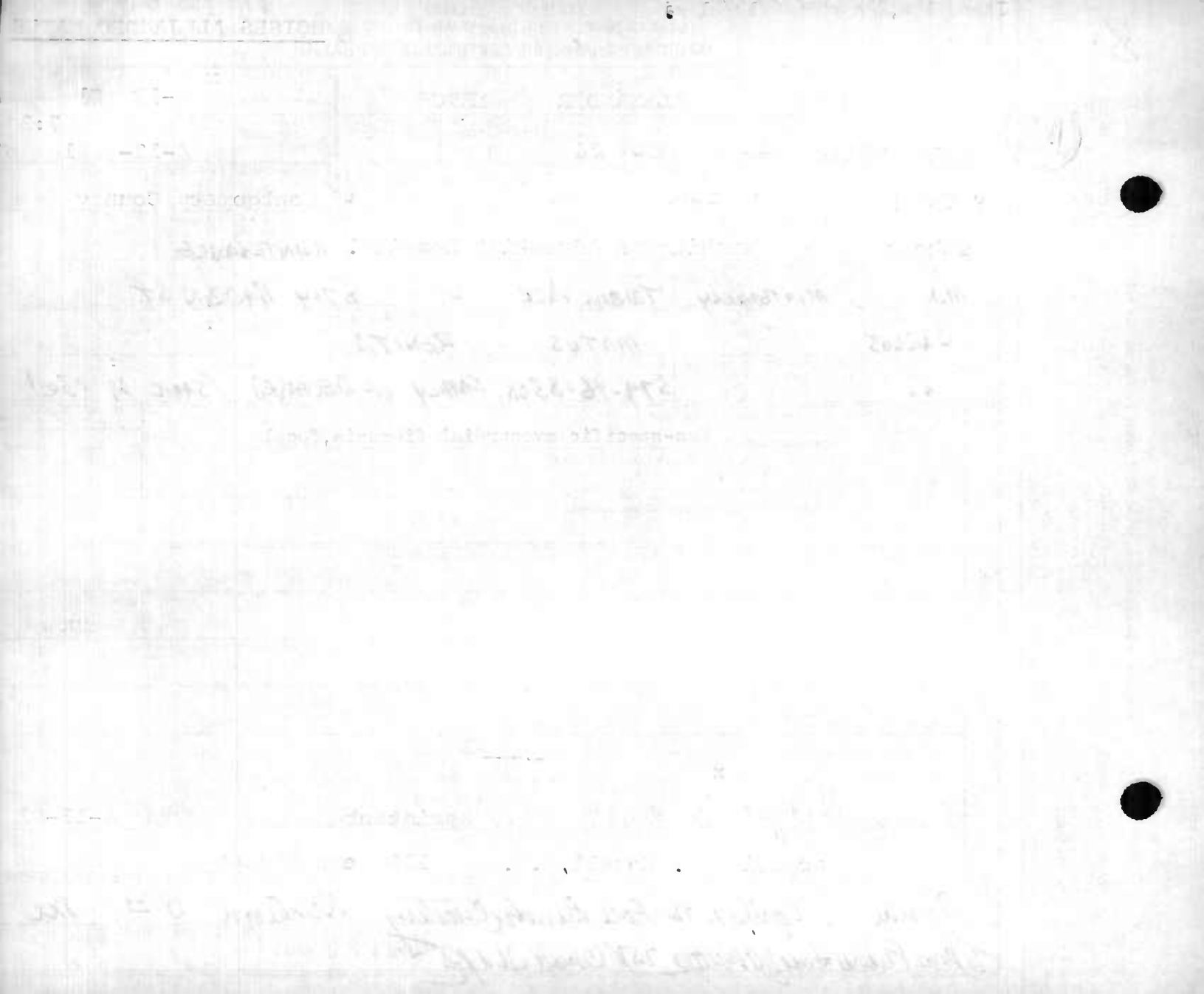
RESIDENCE: [illegible]  
CITY: [illegible]  
STATE: [illegible]

THOMAS [illegible]  
MARTIN [illegible]  
ALICE [illegible]  
KNOX [illegible]  
230-48-1204 Gladys Martin (Wife) (130)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15A 2/80

| 1- STATE REGISTRAR  |  |                      |  |  |  |                                      |  |   |  | REG. NO.                                   |  |  |  |  |  |                       |  |  |  |
|---|--|----------------------|--|--|--|--------------------------------------|--|---|--|--|--|--|--|--|--|-----------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MOS ES ALEXANDER MATUS</b>   |  |                      |  |  |  |                                      |  |   |  | 2a. DATE KNOWN OF DEATH <b>4-12-81</b>     |  |  |  |  |  |                       |  |  |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH <b>AUG 5 1954</b>   |  | 6. AGE (IN YEARS) <b>26 YRS.</b>     |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |  | 7c. DATE PRONOUNCED DEAD <b>4-12-1981</b>  |  | 2b. HOUR <b>14:30</b>  |  | 2c. DATE PRONOUNCED DEAD <b>4-12-1981</b>    |  | 2d. HOUR <b>14:30</b> |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CHILE</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>CHILE</b>  |  |                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>                    |  |  |  |                       |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b> |  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAINTENANCE</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                       |  |  |  |
| 13a. STATE <b>MD.</b>   |  |                      |  | 13b. COUNTY <b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN <b>TAKOMA PARK</b> |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>8704 BARRON ST.</b> |  |  |  |  |  |                       |  |  |  |
| 14. FATHER'S NAME <b>CARLOS</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME <b>BENITA</b>   |  |                                      |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |  |  |  |  |  |  |  |                       |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>579-96-8308</b>   |  |                      |  | 17. INFORMANT ADDRESS <b>FAMILY OF DECEASED (SAME AP 13e)</b>  |  |                                      |  |   |  |  |  |  |  |  |  |                       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Non-specific myocardial fibrosis, focal</b><br><b>4290</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____   |  |                      |  |  |  |                                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                       |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                      |  |  |  |                                      |  |   |  |  |  |  |  |  |  |                       |  |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                      |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                       |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |                       |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |                       |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |                                      |  |   |  |  |  |  |  |  |  |                       |  |  |  |
| ACTUAL SIGNATURE <b>Margareta A. Korell</b>   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>   |  |                                      |  | DATE SIGNED <b>4-13-81</b>  |  |  |  |  |  |  |  |                       |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street</b>   |  |                                      |  |   |  |  |  |  |  |  |  |                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>   |  |                      |  | 23b. DATE <b>April 17, 1981</b>  |  |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>   |  |  |  | 23d. LOCATION <b>Baltimore P.D. Md</b>   |  |  |  |                       |  |  |  |
| 24. FUNERAL DIRECTOR <b>Takoma Funeral Home</b>   |  |                      |  | 25. DATE REC'D BY REGISTRAR <b>APR 20 1981</b>   |  |                                      |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |  |  |  |  |  |                       |  |  |  |



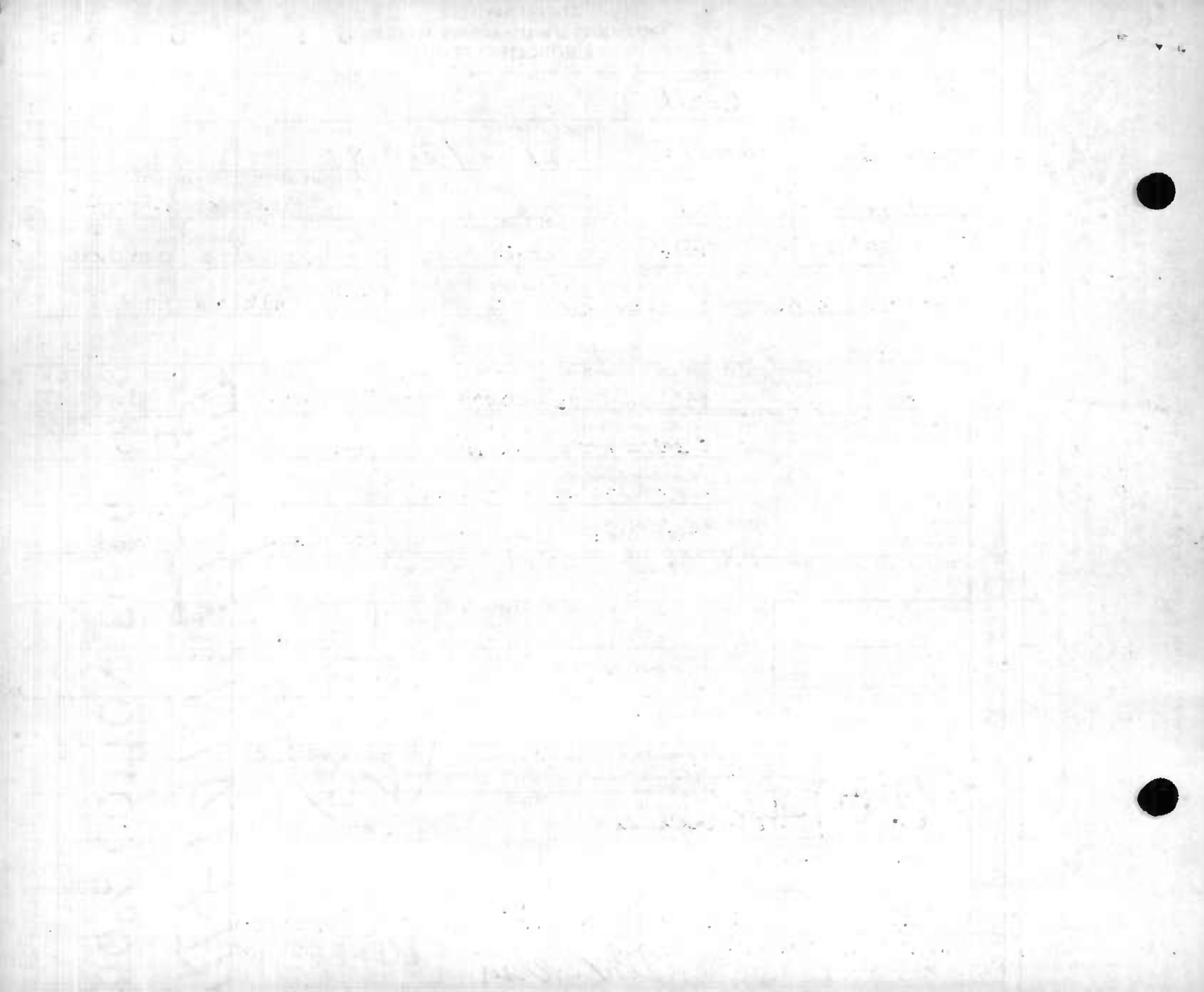


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |  |  |  |  | 8 1 10 9 3 9   |          |   |  |                               |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|----------|---|--|-------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  | REG. NO. |   |  |                               |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST<br>Ella   |  |  | MIDDLE<br>CECIL  |  |  | LAST<br>Maxwell  |  |          | 2a. DATE OF DEATH MONTH DAY YEAR<br>4 20 81   |  |                               | 2b. HOUR<br>2:05P M                        |  |  |
| 3 SEX<br>FEMALE   |  |  | 4 RACE<br>WHITE   |  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>8 / 19 / 83  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>97 YRS.  |  |          | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 74 HRS.<br>HOURS MIN |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County- MD.   |  |          |   |  |                               |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Silver Spring   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Colonial Villa Nursing Home |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  |          | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home   |  |                               |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Montgomery  |  |  | 13c. CITY OR TOWN<br>Sil. Spr.   |  |          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                               | 13e. STREET ADDRESS<br>1529 Falkland Lane, |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George M. Cecil,   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sara Roelke   |  |  |  |  |  |  |  |          |   |  |                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>----- 213-56-6095   |  |  | 17. INFORMANT (son) 5202 Edgemere Court,<br>George Maxwell-Camp Sprs., Md. 20031   |  |  |  |  |          |   |  |                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Cardiac arrest secondary to arrhythmia<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b). Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c). Arteriosclerotic cardiovascular disease |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>sudden<br>unknown<br>unknown |          |   |  |                               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |  |   |  |  |  |  |  |  |  |          |   |  |                               |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |   |  |                               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |          |   |  |                               |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |          |   |  |                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 16, 1976, to April 20, 1981, that (I) (we) last saw the deceased alive on April 20, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.           |  |  |   |  |  |  |  |  |  |  |          |   |  |                               |  |  |  |
| 22b. SIGNATURE<br>Carl J. Houmann   |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  | 22c. DATE SIGNED<br>4-20-81  |  |          |   |  |                               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Carl J. Houmann, M.D.  |  |  | 22e. ADDRESS<br>4404 Queensbury Road, Riverdale, Md. 20840  |  |  |  |  |  |  |  |          |   |  |                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>4-23-81  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meth. Ch Hyattstown Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hyattstown Md.   |  |          |   |  |                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.  |  |  | 25a. DATE RECD. BY REGISTRAR<br>4-23-81   |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |  |          |   |  |                               |  |  |  |
| 8434 Ga. Ave., S.S. Md.   |  |  |   |  |  |  |  |  |  |  |          |   |  |                               |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 0 9 4 0   |   |
|---|--|--|--|---|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AUDREY Carah MC CARTHY</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>April 19, 1981</b> <b>P M</b>                              |   |   |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>Caucasian</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 26 1905</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   | # UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS<br>HOURS MIN                        |   |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sloatsburg, NY</b>   | 7c CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>Sandy Spring</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Friends Nursing Home</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>N. J.</b>  | 13b COUNTY<br><b>Ocean</b>   | 13c CITY OR TOWN<br><b>Whiting</b>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>505 B. Lilac Lane</b>                                      |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin F. Symons</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Moffat</b>   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>080012145</b>  | 17 INFORMANT ADDRESS<br><b>Med. Records</b>  |  |   |   |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL DISEASE</b>  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>   |
| 4409 } DUE TO OR AS A CONSEQUENCE OF (b) <b>ALZHEIMERS DISEASE</b>  |  |  |  |   | <b>YRS</b>  |
| DUE TO OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b>   |  |  |  |   | <b>YRS</b>  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3/5</b> 19 <b>81</b> to <b>4/19</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/11</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did (did not) view the body after death. |  |  |  |   |   |
| 22b SIGNATURE<br><b>D. R. Lewis M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |  | 22c DATE SIGNED<br><b>4/20/81</b>   |   |
| 27a PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. R. LEWIS M.D.</b>   |  | 27b ADDRESS<br><b>OLNEY, MARYLAND 20832</b>  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b DATE<br><b>April 20, 1981</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Lee Crematory</b>                                      |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D. C.</b>   |
| 24 FUNERAL DIRECTOR<br><b>Francis H. Barber</b>   |  | <b>Laytonsville, Md. 20760</b>   |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br><b>APR 21 1981</b>        |   |

10:53  
P

April 19, 1981

MC CARTHY

G.P.

AUREY

75

1905

26

Nov

Caucasian

Female

X

Montgomery

USA

Albany, NY

Bandy Spring Florida Nursing Home

505 B. Hill Lane

X

Whiting

M. J.

Mollie

Elizabeth

Mary

Symona

F.

Edwin

Med. Records

000012145

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR   |  |                         |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |   |  |  |  | REG. NO. 10941                       |  |                          |  |  |  |  |  |  |  |
|---|--|-------------------------|--|---|--|--|--|---|--|--|--|---|--|---|--|---|--|--|--|--------------------------------------|--|--------------------------|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lydia I. McCormick</b>  |  |                         |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTI-MATED<br>MONTH DAY YEAR<br><b>4-09-81</b>             |  |   |  |   |  |   |  |  |  | 2b. HOUR<br><b>10 AM</b>             |  |                          |  |  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 19 99</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>81</b> |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>   |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>                    |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>4 9 81</b>           |  |   |  |   |  |  |  |                                      |  | 2d. HOUR<br><b>10 AM</b> |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD          |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                   |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |                         |  |   |  |  |  |   |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |  |   |  |   |  |   |  |  |  | 13c. CITY OR TOWN<br><b>BETHESDA</b> |  |                          |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John -- Dodson</b>   |  |                         |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary -- Wilson</b>             |  |   |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>413-40-7107</b>   |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>James V. Day, Same address as # 13.</b>  |  |  |  |   |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                         |  |   |  |  |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b><br><b>INDEF.</b> |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>---</b>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>---</b>   |  |  |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>8:49 AM 4 9 81</b>  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8:49 AM 4 9 81</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>COLLAPSED AT HOME</b>   |  |  |  |   |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>HOME</b>  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5524 WESTBARD AVE BETHESDA MONT MD</b>  |  |  |  |   |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .   |  |                         |  |   |  |  |  |   |  |  |  |   |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Francis C. Mayle</b>   |  |                         |  | TITLE (SPECIFY)<br><b>Dept</b>  |  |  |  | M.D.<br><b>---</b>  |  |  |  | MEDICAL EXAMINER<br><b>---</b>  |  |   |  | DATE SIGNED<br><b>4/09/81</b>   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Francis C. Mayle</b>  |  |                         |  | ADDRESS<br><b>8200 Wisconsin Ave Bethesda MD</b>  |  |  |  |   |  |  |  |   |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial/Transit</b>  |  |                         |  | 23b. DATE<br><b>4/10/81</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frasiers Chapel Cemetery Sparta, Tennessee</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SPARTA TENNESSEE</b> |  |   |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>   |  |                         |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>                                |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. H. H.</b>                                |  |   |  |  |  |                                      |  |                          |  |  |  |  |  |  |  |



40

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR OFFICE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. STATE REGISTRAR   |  | 2. DECEASED NAME<br>FIRST <b>JEFFERY</b> MIDDLE <b>WAYNE</b> LAST <b>McDANIEL</b>   |  |  |  |   |  | REG. NO. <b>10942</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. AGE (IN YEARS)<br><b>23</b> YRS.  |  | 6. IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>                           |  | 7a. DATE KNOWN OF DEATH<br><b>April 12, 1981</b>                            |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D. C.</b>  |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>   |  | 2c. DATE PRONOUNCED DEAD<br><b>April 12, 1981</b>                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BROOKEVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>Brookville Brighton Park</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br><b>HEAVY EQUIP. OPERATOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCT.</b>  |  |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b>  |  | 13e. STREET ADDRESS<br><b>16th St. Apt. 14</b>                              |  |
| 14. FATHER'S NAME<br>FIRST <b>JACK</b> MIDDLE <b>E.</b> LAST <b>McDANIEL</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>GRACE</b> MIDDLE <b>A.</b> LAST <b>DeWITT</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-72-3107</b>  |  | 17. INFORMANT<br><b>Jack E. McDaniel</b>                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9520</b><br>IMMEDIATE CAUSE (a) <b>Asphyxiation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>Carbon Monoxide</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>None</b>   |  | 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br><b>YES</b>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. April 1981</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>In van exhaust piped in</b>  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Field</b> |  |
| 21f. LOCATION<br>STREET <b>Brookville Brighton Park</b> CITY OR TOWN <b>Mont.</b> COUNTY <b>MD.</b> STATE  |  | 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                       |  | TITLE (SPECIFY)<br><b>Dr. John S. Rogers</b>  |  | DATE SIGNED<br><b>April 17, 1981</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John S. Rogers</b>   |  | ADDRESS<br><b>Silver Spring, Md.</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Apr. 10, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>Francis H. Barber</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  | 25c. LOCATION<br>CITY OR TOWN <b>Rockville</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>                       |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 8 1 1 0 9 4 3                                |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |   | 2a. DATE OF DEATH                            |   |  |  |  |
| FIRST MIDDLE LAST  |  |  |   |   | MONTH DAY YEAR HOUR                          |   |  |  |  |
| Eileen Louise MCINTYRE   |  |  |   |   | April 6 1981 12:32 PM                        |   |  |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR   |  |
| Female   |  | Caucasian  |   | MONTH DAY YEAR<br>Feb. 16 1923  |  | 58  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| District of Columbia   |  | USA  |   |   |  | Montgomery County, MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda   |  | National Naval Medical Center  |   |   |  | Nurse   |  | Public Health  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Maryland   |  | Montgomery   |   | Rockville   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 11319 Commonwealth Dr. Apt. 2                                  |  |
| 14. FATHER'S NAME  |  |  |   |   | 15. MOTHER'S MAIDEN NAME                     |   |  |  |  |
| FIRST MIDDLE LAST  |  |  |   |   | FIRST MIDDLE LAST                            |   |  |  |  |
| James Francis McIntyre   |  |  |   |   | Louise Furniss                               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   |   | 16b. SOCIAL SECURITY NO.                     |   | 17. INFORMANT ADDRESS                                  |  |  |
| Yes  |  |  |   |   | 579 20 9489                                  |   | Lorraine Griffin 5500 Magruder Ave. Camp/ Springs, Md. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) HEMORRHAGE   |  |  |   |   |  |   |  |  |  |
| 1809 DUE TO, OR AS A CONSEQUENCE OF (b) CHEMOTHERAPY   |  |  |   |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) STAGE III B SQUAMOUS CELL CA OF CERVIX  |  |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr. 5 1981, to Apr. 6 1981, that (I) (we) last saw the deceased alive on Apr. 6 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |   |   | DEGREE                                       |   | 22c. DATE SIGNED                                       |  |  |
| Michael S. Opsahl  |  |  |   |   | MD   |   | Apr. 6, 1981   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |   | 22e. ADDRESS                                 |   |  |  |  |
| MICHAEL S. OPSAHL  |  |  |   |   | National Naval Medical Center, Bethesda, Md. |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY           |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                |  |  |
| Burial   |  |  | April 9, 1981   |   | Resurrection Cemetery                        |   | Clinton Prince George Md.                              |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR                |   | 25b. REGISTRAR'S SIGNATURE                             |  |  |
| Robert A. Pumphrey Funeral Home, Bethesda, Md.   |  |  |   |   | APR 10 1981                                  |   | [Signature]  |  |  |

Handwritten notes and diagrams, including a large circle with internal markings and various scribbles.

Handwritten signature or initials.

1901 U. F. M. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 0 9 4 4  |   |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Anne C. McKinley  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>April Apr 20 81                        |  | 2b. HOUR<br>2:00 PM   |
| 3. SEX<br>Female F  | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan 5 1897   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                 |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                      |  |   |
| 10. CITY OR TOWN OF DEATH<br>Chesapeake   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Chesapeake Nat |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                         |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Montgomery  | 13c. STREET ADDRESS<br>5480 Wisconsin Ave, apt 403                                   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Meredith Geddy  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Richardson              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A   |  | 16b. SOCIAL SECURITY NO.<br>577-36-7533   | 17. INFORMANT ADDRESS<br>John McKinley/Son /Son/Rockville, Md. 20853       |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Longtime heart failure<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) Intoxication with alcohol<br>20 yrs<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Cancer |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 weeks<br>20 yrs |
| 19a. DATE OF OPERATION<br>May 77  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Cancer  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 16 Mar 1981 to 20 Apr 1981, that (I) (we) lost saw the deceased alive on 20 Apr 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE<br>Paul D. Noone   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>20 Apr 81  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul D. Noone  |  | 22e. ADDRESS<br>50 W. Edmonston Dr. Rockville, Md.  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>4/24/81   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Nat.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Arlington Va.                             |   |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi F.H./  |  | 11800 New Hampshire Ave Silver Spring, Md. 20904  |  |  |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 9 4 5

|   |  |  |   |  |                                   |
|---|--|--|---|--|-----------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | MONTH DAY YEAR   |   | MONTHS DAYS HOURS MIN.                                     |                                   |
| Lanier P. McLachlen SR  |  | April 10 1981  |   | 6 35 PM  |                                   |
| 2. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |                                   |
| Male  | Caucasian  | December 5, 1989   | 91 YRS  | IF UNDER 24 HRS  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| Washington, D.C.  | United States  |  | Montgomery County MD.   |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda  | Carriage Hill-Bethesda, MD 20014   |  | Banker  |  | Banking                           |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |  |                                   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                                   |
| Maryland  | Montgomery   | Bethesda   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5215 Cedar Lane  |                                   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| Archibald Mc Lachlen  |  | Mary F. Van Horn   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                           |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   |
| Yes   |  | WW I   |   | 10255 Democracy Ln. Lanier P. Mc Lachlen, Jr. Potomac, Md. |                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular accident  
4360  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Generalized arteriosclerosis  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

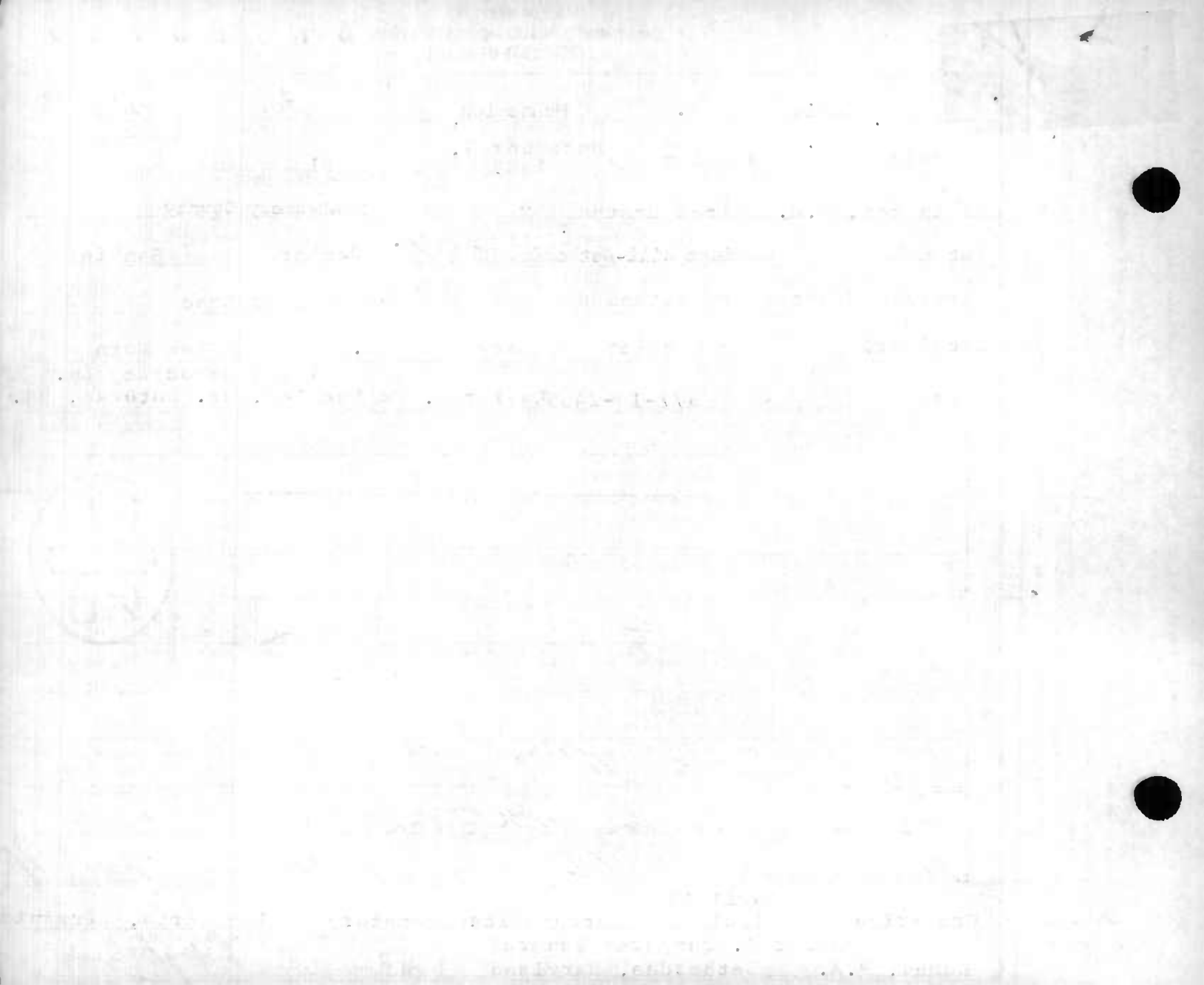
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Anemia

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| None   |  | —  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  | None   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1980</u> to <u>present</u> 19 <u>81</u> , that (I) (we) lost the deceased alive on <u>4/10</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |
| <u>Dr. B. Umhou</u>  |  | MD   |  | 4/10/81  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |
| <u>Dr. B. Umhou</u>  |  | MD 8805 Conn. Ave Chevy Chase Md                                       |  |  |  |  |  |

|   |  |               |  |                                    |  |  |  |
|---|--|---------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                 |  | 23b. DATE     |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Cremation   |  | April 11 1981 |  | Metropolitan Crematory             |  | Alexandria, Virginia                       |  |
| 24. FUNERAL DIRECTOR<br>NAME                              |  |               |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |  |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland |  |               |  | APR 20 1981                        |  | <u>Robert A. Pumphrey</u>                  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                  |   |                                  | 8 1 1 0 9 4 6   |  |  |  |
|--|------------------|---|----------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR   |                  |   |                                  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JOHN B. MEALY  |                  |   | 2a. DATE OF DEATH<br>APR 13 1981 |   |  | 2b. HOUR<br>11A M  |  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>FEB 16, 1909  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D.C.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ADM. LAW JUDGE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DEPT OF LABOR   |  |
| 13a. STATE<br>MARYLAND   |                  | 13b. COUNTY<br>MONTGOMERY   |                                  | 13c. CITY OR TOWN<br>SILVER SPRING  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>MICHAEL O. MEALY  |                  | 15. MOTHER'S MAIDEN NAME<br>CATHERINE CREHAN  |                                  | 13e. STREET ADDRESS<br>409 HAMILTON AVENUE  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |                  | 16b. SOCIAL SECURITY NO.<br>216-44-2769   |                                  | 17. INFORMANT<br>SARAH C. MEALY SAME AS 13 WIFE   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Liver failure - congestive heart failure</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>cardiac pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic heart disease - congestive heart failure</u><br>WKS TO |                  |   |                                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>HRS.<br>MINS.<br>WKS TO  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.   |                  |   |                                  |   |  |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.  |                  |   |                                  |   |  |  |  |
| 22b. SIGNATURE<br>Albert H. Grouman MD   |                  | DEGREE  |                                  | 22c. DATE SIGNED<br>4/13/81   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALBERT H. GROUMAN MD  |  |
| 22e. ADDRESS<br>1106 SILVER SPRING ST. SILVER SPRING MD.   |                  | 22f. ADDRESS  |                                  | 22g. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |                  | 23b. DATE<br>4/15/81  |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS   |                  |   |                                  | 25a. DATE REC'D. BY REGISTRAR<br>APR 15 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaelie Brady   |  |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901   |                  |   |                                  |   |  |  |  |

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |           |  |                                    |  |   |  |  | 8 1 1 0 9 4 7  |  |
|---|--|--|-----------|--|------------------------------------|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |           |  | CERTIFICATE OF DEATH               |  |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |           |  | 2a. DATE OF DEATH                  |  |   | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| RUTH Gardner  |  |  |           |  | MECCS                              |  |   | April 25 1981  |  | M  |  |
| 3. SEX  |  | 4. RACE  |           | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |
| Female  |  | Caucasian  |           | April 23 1898  |                                    | 83   |   | MONTHS DAYS  |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |  |  |
| South Carolina  |  | U.S.A.   |           |  |                                    | Mont Co MD.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |           |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |  |
|   |  | Collingswood Nursing Center  |           |  |                                    | Homemaker  |   | at Home  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |           |  |                                    |  |   |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |           | 13c. CITY OR TOWN  |                                    | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS                                      |  |  |  |
| Maryland  |  | Montgomery   |           | Rockville  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 4900 Ertter Dr.  |  |  |  |
| 14. FATHER'S NAME   |  |  |           |  | 15. MOTHER'S MAIDEN NAME           |  |   |  |  |  |  |
| Unknown   |  |  |           |  | Unknown                            |  |   |  |  | Lewis  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |           |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT ADDRESS                         |  |  |  |  |
| No  |  |  |           |  | 579-24-2582                        |  | Jack Lane 4900 Ertter Dr. Rockville MD. 20853 |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |           |  |                                    |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i>  |  |  |           |  |                                    |  |   |  |  | 5 YRS  |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Unwitnessed Arteriosclerosis</i>   |  |  |           |  |                                    |  |   |  |  | 5 YRS  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senile Dementia</i>  |  |  |           |  |                                    |  |   |  |  | 2 YRS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |           |  |                                    |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |           |  |                                    |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |
|   |  |  |           | P.M. 19  |                                    |  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                    | 21f. LOCATION STREET   |   | CITY OR TOWN   |  | COUNTY STATE   |  |
|   |  |  |           |  |                                    |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1978</i> , 19____, to <i>April 25 1981</i> , that (I) <del>was</del> lost saw the deceased alive on <i>4/22/81</i> 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If <del>you</del> did not view the body after death.) |  |  |           |  |                                    |  |   |  |  |  |  |
| 22b. SIGNATURE  |  |  |           | DEGREE   |                                    |  |   | 22c. DATE SIGNED   |  |  |  |
| <i>Lawrence J. Thomas M.D.</i>  |  |  |           | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                                    |  |   | <i>4/26/81</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |           | 22e. ADDRESS   |                                    |  |   |  |  |  |  |
| LAWRENCE J. THOMAS  |  |  |           | PIKE 11801 ROCKVILLE, MD.  |                                    |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                  |  |  |  |
| Removal Burial  |  |  | 4-29-81   |  | Mt. Hope Cemetery                  |  |   | Florence S. Carolina                                     |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |           |  | ADDRESS                            |  |   |  |  | 25. DATE REG'D. BY REGISTRAR                                   |  |
| Everly-Wheatley F. H.   |  |  |           |  | Alexandria Va.                     |  |   |  |  | APR 30 1981  |  |

MEDICAL CERTIFICATION

9 9

1

BP

X

(1)

(2)

WATER

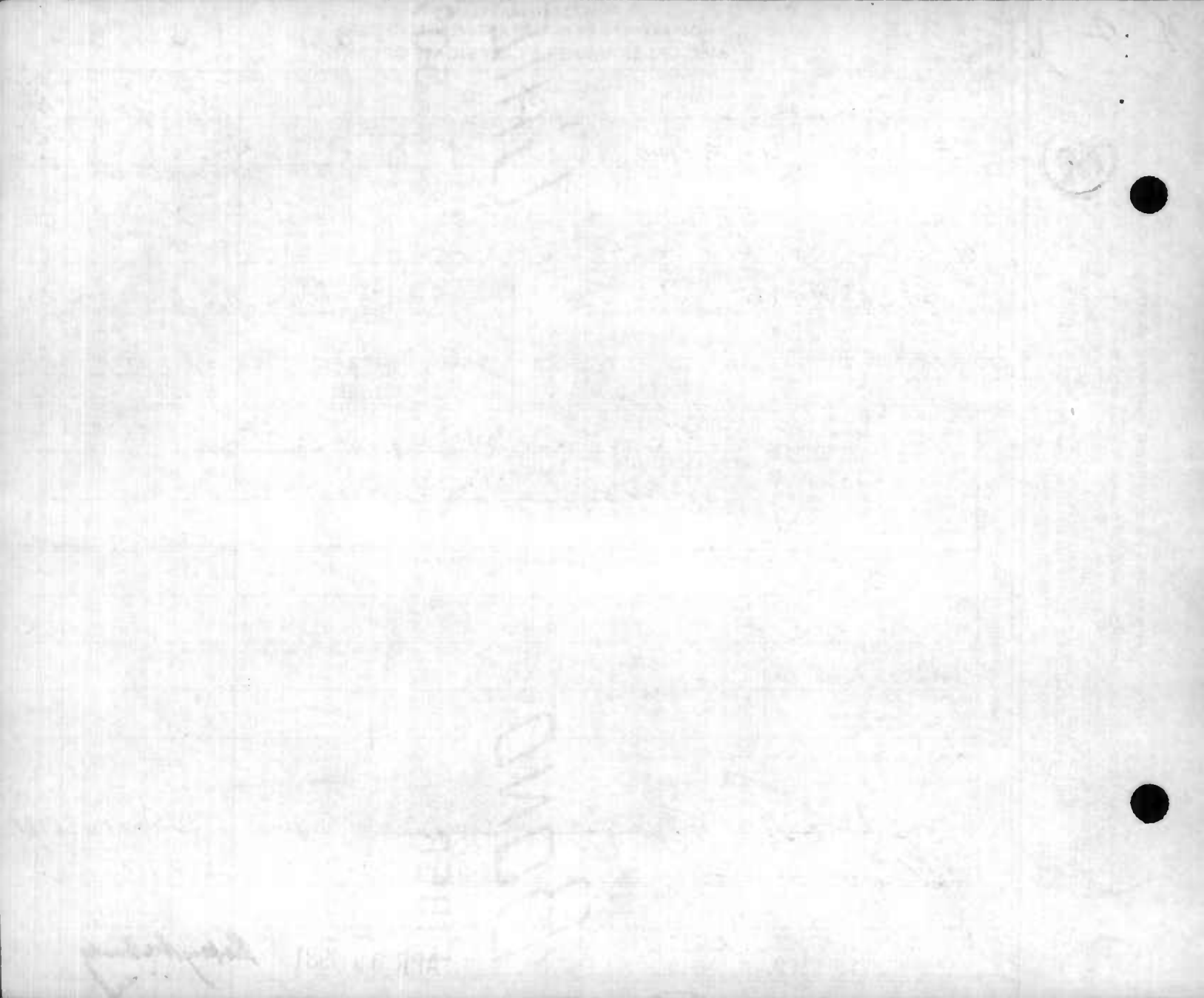
12 FEB 1967

Handwritten notes and text, mostly illegible due to fading. Some visible words include "water", "12 FEB 1967", and "WATER".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |                |   |                  |   |                          | REG. NO. 10943                               |          |  |
|--|---------|--|--|---|----------------|---|------------------|---|--------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |                | LAST  |                  | 2a. DATE KNOWN OF DEATH   |                          | 2b. HOUR                                     |          |  |
| Jennie   |         |  |  |   |                | Meisel  |                  | APR 17 1981   |                          | 2:30 PM                                      |          |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   | IF UNDER 1 YR. |   | IF UNDER 24 HRS. |   | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR |  |
| F  | W       | 4-19-1900  |  | 80 YRS.   |                |   |                  |   | APR 17 1981              |  | 2:30 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  |   |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                          |  |          |  |
| NEW YORK   |         | U.S.A.   |  |   |                | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | Montgomery  |                          | MD.  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |   |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                          |  |          |  |
| Olmsted  |         | Mont. General Hosp.                                      |  |   |                | HOUSEWIFE   |                  |   |                          |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                | 13d. INSIDE CITY LIMITS?  |                  | 13e. STREET ADDRESS   |                          |  |          |  |
| MD   |         | Mont.  |  | Ft. Spg.  |                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                  | 3300 Weeping Willow Cr. Apt 4                                       |                          |  |          |  |
| 14. FATHER'S NAME  |         |  |  | 15. MOTHER'S MAIDEN NAME                                    |                |   |                  | ADDRESS   |                          |  |          |  |
| UNKNOWN  |         |  |  | UNKNOWN   |                |   |                  | 379 COLLEGE DRIVE<br>EDISON, NEW JERSEY                             |                          |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |  |  | 16b. SOCIAL SECURITY NO.                                    |                | 17. INFORMANT   |                  |   |                          |  |          |  |
| NO   |         |  |  | UNKNOWN   |                | DAVID MEISEL  |                  |   |                          |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |         |  |  |   |                |   |                  |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis.   |         |  |  |   |                |   |                  |   |                          |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |                |   |                  |   |                          |  |          |  |
| (b) Chronic Myocardial Dis.  |         |  |  |   |                |   |                  |   |                          |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |                |   |                  |   |                          |  |          |  |
| (c)  |         |  |  |   |                |   |                  |   |                          |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |   |                |   |                  |   |                          |  |          |  |
| None   |         |  |  |   |                |   |                  |   |                          |  |          |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                |   |                  | 20. AUTOPSY?  |                          |  |          |  |
| None   |         |  |  |   |                |   |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY   |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                  |   |                          |  |          |  |
|  |         |  |  | P.M. 19   |                |   |                  |   |                          |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                | 21f. LOCATION   |                  |   |                          |  |          |  |
|  |         |  |  |   |                | CITY OR TOWN COUNTY STATE   |                  |   |                          |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |                |   |                  |   |                          |  |          |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |                |   |                  | DATE SIGNED   |                          |  |          |  |
| John S. Rogers   |         |  |  | M.D. Dep.   |                |   |                  | April 7 1981  |                          |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |                |   |                  |   |                          |  |          |  |
| JOHN S. ROGERS   |         |  |  | 1919 SEMINARY ROAD, SILVER SPRING, MD.                      |                |   |                  |   |                          |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                          |                | 23d. LOCATION   |                  | COUNTY  |                          | STATE  |          |  |
| CREMATION  |         | 4/8/81   |  | METROPOLITAN CREMATORY                                      |                | ALEXANDRIA  |                  | VIRGINIA  |                          |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |         |  |  | 25a. DATE REC'D. BY REGISTRAR                               |                |   |                  | 25b. REGISTRAR'S SIGNATURE  |                          |  |          |  |
| FRANCIS J. COLLINS   |         |  |  | 20901 APR 09 1981   |                |   |                  | Rafay, R. R.  |                          |  |          |  |
| 500 UNIVERSITY BLVD., W., SILVER SPRING, MD. 20901   |         |  |  |   |                |   |                  |   |                          |  |          |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

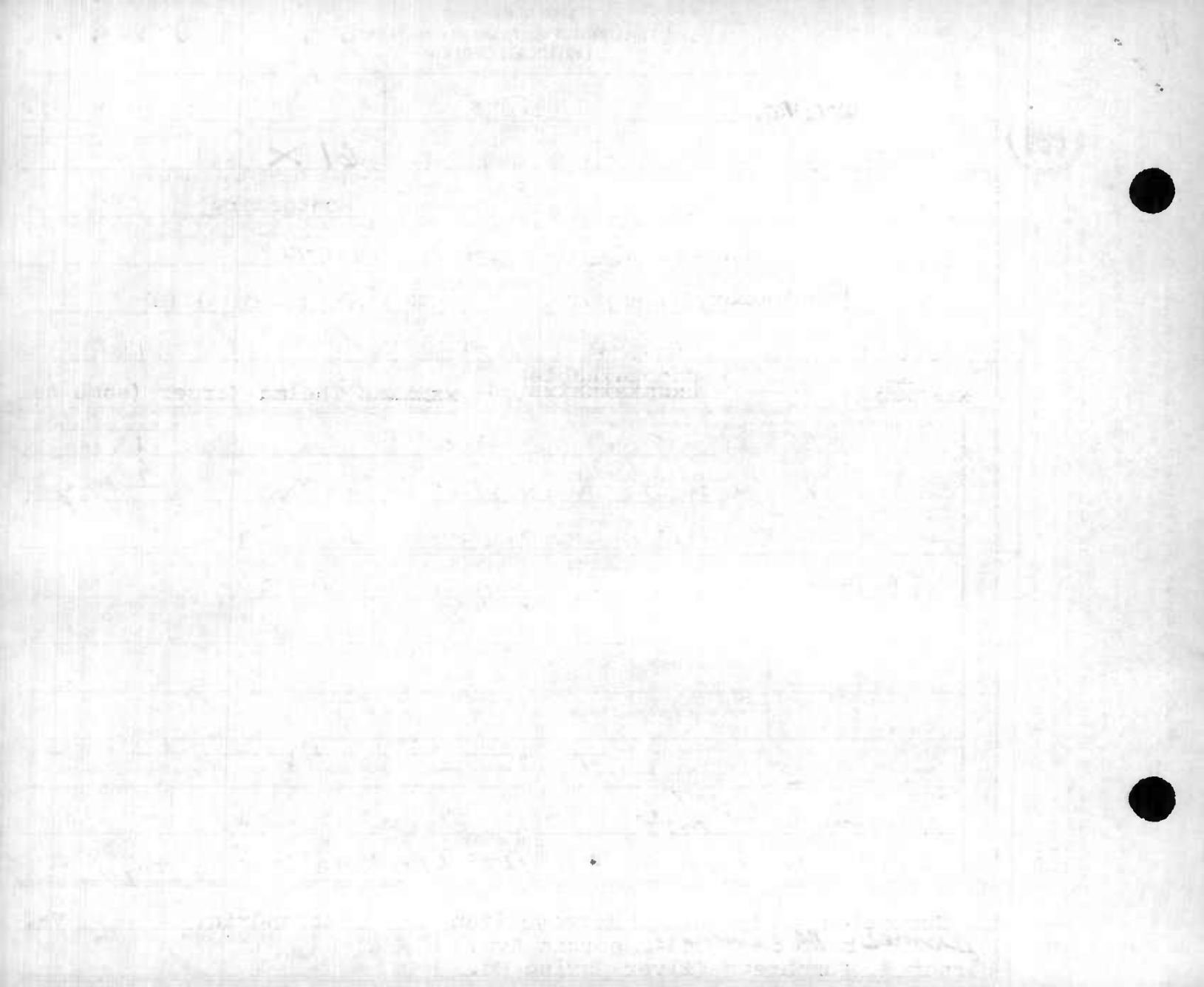
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |
|---|--|--|--|--|--------------------------|--|-------------------|--|-----------------------------|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 1 1 0 9 4 9            |  |                   |  |                             |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH        |  |                   |  |                             |  |  |  |  |  |
| WOODROW MERCER  |  |  |  |  | 4 3 81 6:33 PM           |  |                   |  |                             |  |  |  |  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |                   | 7. IF UNDER 1 YEAR   |                             |  |  |  |  |  |
| MALE  |  | WHITE  |  | 3 7 20   |                          | 61 YRS   |                   | MONTHS DAYS HOURS MIN.   |                             |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                   |  |                             |  |  |  |  |  |
| NC  |  | USA  |  |  |                          | Montgomery MD.   |                   |  |                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                   | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |  |  |  |  |  |
| TAKOMA PARK   |  | WASHINGTON ADVENTIST HOSPITAL  |  |  |                          | MAINTENANCE  |                   |  |                             |  |  |  |  |  |
| 13a. STATE  |  |  |  |  | 13b. COUNTY              |  | 13c. CITY OR TOWN |  | 13d. STREET ADDRESS         |  |  |  |  |  |
| MD  |  |  |  |  | Montgomery               |  | SPENNERVILLE      |  | 16012 BAYSON ROAD           |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME |  |                   |  |                             |  |  |  |  |  |
| WILLIAM E. MERCER   |  |  |  |  | EFFIE HIGH               |  |                   |  |                             |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  |  | 16b. SOCIAL SECURITY NO. |  |                   |  |                             | 17. INFORMANT ADDRESS  |  |  |  |  |
| XXXXXX  |  |  |  |  | unobtainable             |  |                   |  |                             | WIFE XXXXXX Thelma Mercer (same as)                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                          |  |                   |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 4100 Cardiac Arrest   |  |  |  |  |                          |  |                   |  |                             | 15 min   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction  |  |  |  |  |                          |  |                   |  |                             | 2 days   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease  |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c):  |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |
| Brain Death Secondary to Angina   |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |  |                   | 20a. AUTOPSY?  |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
|   |  |  |  |  |                          |  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                             | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                          |  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                             |  |  |  |  |  |
|   |  |  |  | P.M. 19  |                          |  |                   |  |                             |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          |  |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                             |  |  |  |  |  |
|   |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 77, to April 13 81, that (I) (we) last saw the deceased alive on April 3 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |                          | DEGREE   |                   |  | 22c. DATE SIGNED            |  |  |  |  |  |
| Morton A. Trschuler M.D.  |  |  |  |  |                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                   |  | 4/3/81                      |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |                          | 22e. ADDRESS   |                   |  |                             |  |  |  |  |  |
| Morton A. Trschuler M.D.  |  |  |  |  |                          | 1299-LAMBERTA DR. Silver Spring, Md.   |                   |  |                             |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |                   |  |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |  |  |
| Cremation   |  |  |  | 4-5-81   |                          | Metropolitan   |                   |  |                             | Alexandria Va.   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |                          | 24b. ADDRESS   |                   |  | 25a. DATE RECD BY REGISTRAR |  |  |  |  |  |
| Warner E. Pumphrey  |  |  |  |  |                          | 8434 Georgia Ave.  |                   |  | APR 9 1981                  |  |  |  |  |  |
|   |  |  |  |  |                          |  |                   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
|   |  |  |  |  |                          |  |                   |  |                             |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

DHMH-16 30M 2/80  
(VRA 13, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |                                    |   |  |
|---|--|---|---|--|------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kate KATE L Merritt MERRITT</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>81</b> |  | 2b. HOUR <b>6</b> <sup>30</sup> AM |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>88</b>  |                                    | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>92</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>D.C.</b>   |  | 13b. COUNTY<br><b>Washington</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    | 13e. STREET ADDRESS<br><b>5437 Conn. Ave., N.W.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Alexander</b> LAST <b>Wadkins</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Georgia</b> MIDDLE <b>Elizabeth</b> LAST <b>Tillery</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |                                    | 16b. SOCIAL SECURITY NO.<br><b>340-38-3530</b>  |  |
| 17. INFORMANT<br><b>Thomas H Goss</b>   |  | 18. ADDRESS<br><b>1301--20th St., N.W. Wash.</b>  |   | 19. DATE OF OPERATION  |                                    | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Dis.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Generalized arteriosclerosis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>20 yrs</b><br><b>20 yrs</b>  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Congestive Heart Failure</b>   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                    | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   | 22a. I certify that (I) (this hospital) attended the deceased from <b>3/4/81</b> , 19, to <b>4/2/81</b> , 19, that (I) (we) last saw the deceased alive on <b>3/26/81</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                    | 22b. SIGNATURE<br><b>Henry C. Scruggs MD</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED<br><b>4/2/81</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henry C. Scruggs MD</b>   |   | 22e. ADDRESS<br><b>5413 Cedarha. Bethesda Md.</b>  |                                    | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial/Removal</b>  |  |
| 23b. DATE<br><b>4/8/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Notasulga Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Notasulga Alabama</b>   |                                    | 24. FUNERAL DIRECTOR<br>NAME <b>Joseph Gawler's Sons Inc</b> ADDRESS<br><b>5130 Wisc. Ave., N.W. Wash., D.C.</b>  |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |   | 25c. REGISTRAR'S SIGNATURE   |                                    | 25d. REGISTRAR'S SIGNATURE  |  |

SECRET

X

• • •

one

2000

• • • • •

• •

1992

2000

1. *Introduction*

• • • • •

O

• • • • •

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frances S. Mesh</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 10 81</b> |   |  | 2b. HOUR<br><b>130 P.M.</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 01 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>New York</b>                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>                                  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13b. STREET ADDRESS<br><b>6820 Granby Street</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rubin SKLON</b>                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida ALPERT</b>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>055-10-2644</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Aaron Tollin; 6820 Granby St, Beth, Md.</b>  |  |  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic C.V. Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-----</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 yrs</b><br><b>10 days</b> |
|--|--|---|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK               |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-4</b> 19 <b>79</b> , to <b>4-10</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-10</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Bernard H. Ostrow</b>  |  | 22c. DATE SIGNED<br><b>4-10-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD H. OSTROW, M.D.</b>   |  | 22e. ADDRESS<br><b>5225 Pooks Hill Road, Bethesda, Md.</b>   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                  |  | 23b. DATE<br><b>4-12-81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Beth David Cemetery Elmont, L.I., New York</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b> |  |                             |  | DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 15 1981</b>               |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 10 9 5 2   |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Bertha S. Metzler   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 9 81  |  | 2b. HOUR<br>10:30 PM   |  |
| 3 SEX<br>F  |  | 4 RACE<br>W   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 26 1888   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Cherry Chase   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7105 Lenhart Dr. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Teacher  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>D.C. Schools  |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>Mont.   |  | 13c. CITY OR TOWN<br>Cherry Chase  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Schuchardt   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leola Berry   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>---   |  |   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>579 40 5899  |  | 17. INFORMANT<br>ADDRESS<br>Richard Metzler 7208 Pomander Ln<br>Cherry Chase Md.   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) heart failure<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) stroke<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>3 weeks |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 4-9 19 81 to 4-9 19 81, that (b) (we) lost saw the deceased alive on 4-9 19 81 and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) did (did not) view the body after death.           |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Neil A. Crane   |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>4-9-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NEIL A. CRANE  |  |   |  | 22e. ADDRESS<br>5480 Wisconsin Ave #228<br>Cherry Chase Md 2085  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4-13-1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville Montgomery Md.   |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| 8434 Ga. Ave., S.S. Md.   |  |   |  | APR 15 1981  |  | [Signature]  |  |

APR 12 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6 G 555 5/25/81 GB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 9 5 3

1- STATE REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SALLY</b>         |  |  | FIRST<br><b>MICHAEL</b>  |  |  | LAST   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-29-81</b>   |  |  | 2b. HOUR<br><b>6 A</b> M                          |  |  |
| 3 SEX<br><b>Female</b>                                      |  |  | 4 RACE<br><b>white</b>   |  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-06-06</b>  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> <b>73</b> YRS.                                      |  |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>73</b>   |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b> |  |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                    |  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Takoma Park</b>              |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sligo Gardens Nursing Home</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary (Ret) Office</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |
| 13a. STATE<br><b>Maryland</b>                               |  |  | 13b. COUNTY<br><b>Montgomery</b>   |  |  | 13c. CITY OR TOWN<br><b>Sil. Spg.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>8107 Eastern Avenue</b> |  |  |

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jack Gilvar</b>                       |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Grant</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |  | 16b. SOCIAL SECURITY NO<br><b>081-24-7961</b>                       |  |  |
| 17 INFORMANT<br><b>Beth Gitlitz, Gr-Daughter; Wheaton, Md.</b>                    |  |  | ADDRESS<br><b>2924 Bel Pre Rd.</b>                                  |  |  |

|   |  |   |
|---|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 10</b> 19 <b>80</b> , to <b>APRIL 29</b> 19 <b>81</b> , that (1) (we) lost saw the deceased alive on <b>4/16</b> 19 <b>81</b> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Mark H. Sig, M.D.</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/29/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK H. SIG, M.D.</b>   |  | 22e. ADDRESS<br><b>9801 GEORGIA AVE. SILVER SPRING, MD. 20902</b>      |  |  |  |  |  |

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                         |  | 23b. DATE<br><b>May 1, 1981</b>                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King David Mem. Gdn. Falls Church, Virginia</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Md.</b> |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b> |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 1 1981</b> |  | 25. REGISTRAR'S SIGNATURE  |  |   |  |

(5)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DDMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 1 0 9 5 4   |  |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| JOHN GLEASON MILES, JR.  |  |  |  | APRIL 20, 1981  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |
| MALE   |  | WHITE  |  | APRIL 24, 1941  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Minn.  |  | U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| BETHESDA   |  | THE CLINICAL CENTER  |  | Legal Editor  |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS   |  |
| MARYLAND   |  | Montgomery   |  | 6334 WESTERN AVENUE 20015   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |   |  |
| John G. Miles  |  |  | Ruth Van Braak                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |
| No   |  | 553-56-3104  |  | MRS. PEGGY MILES (NOK) SAME AS ABOVE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>  |  |  |  |   |  |
| 1919   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (we) (this hospital) attended the deceased from <u>MARCH 24, 1981</u> , to <u>APRIL 20, 1981</u> , that (we) last saw the deceased alive on <u>APRIL 20, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| MK Gumerlock MD  |  | MK Gumerlock MD  |  | 4/21/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |
| mk Gumerlock   |  | NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MD. 20205                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | 4/25/81  |  | Gate of Heaven Cem.   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR  |  |   |  |
| Silver Spring, Md.   |  | APR 21 1981  |  |   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. REGISTRAR'S SIGNATURE  |  |
| Joseph Gawler's Sons, Inc.   |  | 5130 Wisc. Ave. N.W. Wash., D.C. 20016   |  | [Signature]   |  |



THE J. C. KELLEY CO., INC.  
1000 E. WASHINGTON ST., CHICAGO, ILL.  
J. C. KELLEY CO., INC.  
1000 E. WASHINGTON ST., CHICAGO, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT Joseph Miller</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/29/81</b>                |   |  | 2b. HOUR<br><b>5:45 AM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 31, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>FLORIDA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1604 DENNIS AVENUE</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK MILLER</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA SYDERER</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-01-8399</b>  |  | 17. INFORMANT<br><b>CARMELLA MILLER</b>   |  | ADDRESS<br><b>SAME AS 13 WIFE</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRAGE</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA LEFT LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>8 months</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 20</b> , 19 <b>75</b> , to <b>APRIL 29</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>APRIL 29</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Hubert J. Alpert</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>4/29/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HUBERT J. ALPERT</b>  |  |   |  | 22e. ADDRESS<br><b>8630 FENTON ST.<br/>SILVER SPRING, MD. 20910</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/2/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT MARYLAND</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |
| ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |  |   |  |   |  |  |  |

1912/11/14

(11)

The following is a list of the names of the persons who have been named in the various reports of the Committee on the subject of the proposed amendment to the Constitution of the State of New York, as passed by the Senate on the 14th day of November, 1912.

X

The following is a list of the names of the persons who have been named in the various reports of the Committee on the subject of the proposed amendment to the Constitution of the State of New York, as passed by the Senate on the 14th day of November, 1912.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 0 9 5 6  |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br><i>William J. Miller Sr.</i>  |  |   |  | MONTH DAY YEAR<br><i>April 19 1981</i>   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>Caucasian</i>   |  | 2b. HOUR<br><i>8:42 P.M.</i>   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Dec. 4, 1921</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><i>59</i> YRS.   |  | 7b. HOUR   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County, MD.</i>                    |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rockville</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Shady Grove Adventist Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Dir. of Research</i> |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Montgomery</i>  |  | 13c. CITY OR TOWN<br><i>Barnestown</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Robert Miller</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Dorothy Not available</i>   |  | 13d. STREET ADDRESS<br><i>5415 Quail Run Drive</i>                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>WW II 173 12 8746</i>  |  | 17. INFORMANT ADDRESS<br><i>Catherine C. Miller Same as item 13</i>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiogenic shock</i><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>coronary artery disease</i>  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (ALL NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a))  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>April 18</i>   |  | 21f. LOCATION<br>CITY OR TOWN STREET COUNTY STATE<br><i>April 19</i>                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 18</i> , 19 <i>81</i> , to <i>April 19</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>April 18</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Mark F. Weinstein MD</i>  |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>April 19, 1981</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARK F. WEINSTEIN MD</i>   |  | 22e. ADDRESS<br><i>11125 Rockville Pike Rockville, Md.</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>April 23, 1981</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Joseph's</i>                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Scranton, Pennsylvania</i>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</i>  |  | 25. REGISTERAR'S SIGNATURE<br><i>APR 26 1981</i>  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |   |  |
|---|--|--|--|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Alice B. Mills</i>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>4 25 81</i> 2b. HOUR<br><i>7:46 A.M.</i>   |  |   |   |  |
| 3. SEX<br><i>FEMALE</i>   |  | 4. RACE<br><i>WHITE</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>11 01 09</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS.  |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  |  | 7b. CITIZENSHIP<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY</i> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>VICE PRES. CITIZENS SAVINGS &amp; LO</i>                               |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Montgomery</i>   |  | 13c. CITY OR TOWN<br><i>Silver Spring</i>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><i>604 Clover Field Pl</i>             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>GEORGE BUXTON</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>GRACE CARNAHAN</i>  |  |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>217-32-1574</i>   |  | 17. INFORMANT ADDRESS<br><i>RUSSELL E. MILLS SAME AS 13 HUSBAND</i>   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i><br><i>1539</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of colon</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><i>1975</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Carcinoma of colon</i>  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>Non</i>  |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 19 68</i> to <i>present</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>4/24</i> 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><i>John B. Umhau</i>  |  |  |  | DEGREE<br><i>MD</i>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>4/25/81</i>                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>John B. Umhau</i>   |  |  |  | 22e. ADDRESS<br><i>8805 Conn. Ave. Chevy Chase Md</i>   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>4/28/81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ST. MARKS CHURCH</i>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>PETERSVILLE FREDERICK MD.</i>  |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>FRANCIS J. COLLINS</i>  |  |  |  | 24b. ADDRESS<br><i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 28 1981</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Robert J. ...</i>            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 9 5 8

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Last: <u>Modlin</u><br>First: <u>Lola</u><br>Middle: <u>P</u> |  |  | 2a. DATE OF DEATH<br>MONTH: <u>4</u> DAY: <u>3</u> YEAR: <u>81</u><br>2b. HOUR: <u>11:45</u> M |  |  |
| 3. SEX<br><u>Female.</u>   |  | 4. RACE<br><u>White.</u>   |  | 5. DATE OF BIRTH<br>MONTH: <u>May</u> DAY: <u>7</u> YEAR: <u>1886</u>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>94</u> YRS   |  | 7. BIRTHPLACE (STATE OR FOREIGN)<br><u>Winchester, Indiana</u>   |  | 8. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montg.</u> MD.  |  | 10. CITY OR TOWN OF DEATH<br><u>Kensington, Md.</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Circle Manor Nursing Home.</u> |  |
| 12. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Retired School Teacher.</u>    |  | 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE: <u>Md.</u> 13b. COUNTY: <u>Montg.</u> 13c. CITY OR TOWN: <u>Kensington.</u> |  | 14. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 15. STREET ADDRESS<br><u>10231 Carroll Pl.</u>   |  | 16. FATHER'S NAME<br>First: <u>Not Known.</u> Middle: <u></u> Last: <u></u>  |  | 17. MOTHER'S MAIDEN NAME<br>First: <u>Not Known.</u> Middle: <u></u> Last: <u></u>   |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO.</u>                    |  | 19. SOCIAL SECURITY NO.<br><u>311-09-1830</u>  |  | 20. INFORMANT<br><u>D. Edward Modlin ( Son )</u>   |  |
| 21. ADDRESS<br><u>28 Keystone Dr. Gaithersburg, Md.</u>  |  |  |  |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <u>Cardio-Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b): <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c): <u></u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 Days</u> |
|---|--|---|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Arteriosclerotic Cardiovascular Disease</u>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <u>81</u>   |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> , 19 <u>81</u> , to <u>April 3</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>March 31</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22c. DATE SIGNED<br><u>4-4-81</u>                                      |  |
| 23a. SIGNATURE<br><u>Benjamin Aronow, M.D.</u>  |  | 23b. ADDRESS<br><u>3720 Furman Ave. New Md. 20795</u>                  |  |
| 24a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BENJAMIN ARONOW, M.D.</u>   |  | 24b. ADDRESS<br><u>3720 Furman Ave. New Md. 20795</u>                  |  |

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 25a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u> |  | 25b. DATE<br><u>Apr. 8, 1981</u>                |  | 25c. NAME OF CEMETERY OR CREMATORY<br><u>St. Joseph Valley</u> |  | 25d. LOCATION<br>CITY OR TOWN: <u>St. Joseph</u> COUNTY: <u>Granger, Indiana</u> STATE: <u>INDIANA</u> |  |
| 26. FUNERAL DIRECTOR<br><u>Robert Walters</u>                 |  | 27. ADDRESS<br><u>254 Carroll St. N. W. 208</u> |  | 28. REGISTRAR'S SIGNATURE<br><u>APR 8 1981</u>                 |  | 29. REGISTRAR'S SIGNATURE<br><u>APR 8 1981</u>   |  |

|     |  |            |
|-----|--|------------|
| No. | 311-00-1830 R. Edward Modlin ( Son ) and. Md.                      | Not Known. |
|     | 38 Keystone Dr. Calhoun  | Not Known. |
|     | 10231 Carroll St.  | Monte.     |
|     | Kennington.  | Monte.     |
|     | Kennington, Md. Circle Manor Nursing Home. Retired School Teacher. |            |
|     | Winchester, Indiana U. S. A.                                       |            |
|     | Female. White.   |            |
|     | May 7, 1906  |            |
|     | 94   |            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHWM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dorothy E. Manfreda</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-7-81</b> |   |  | 2b. HOUR<br><b>4:41 P.M.</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 23 16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. TRANS.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>KENSINGTON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>4213 COLCHESTER DRIVE</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT BOISSEAU</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNE WOLFE</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>134-12-7532</b>   |  | 17. INFORMANT<br><b>DAUGHTER</b>  |  | ADDRESS<br><b>SAME AS 13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL ANOXIC BRAIN DAMAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETIC KETOACIDOSIS WITH HYPERKALEMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b><br><b>4 DAYS</b><br><b>4 DAYS</b>                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>1) HYPOTHYROIDISM 2) PERICARDIAL EFFUSION &amp; TAMPOONADE</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>4/2/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PERICARDIAL EFFUSION &amp; TAMPOONADE</b>                                      |  |   |  | 20a. AUTOPSY?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>11125 ROCKVILLE PIKE, ROCKVILLE, MD.</b>  |  |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>MARCH 19 80</b> to <b>4/7 81</b> , that (I, we) lost sight of the deceased on <b>4/7 81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Roger Stevenson, Jr MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/7/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROGER STEVENSON, JR MD</b>  |  |   |  | 22e. ADDRESS<br><b>11125 ROCKVILLE PIKE, ROCKVILLE, MD.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>APR. 11, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT. MD.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  |   |  | ADDRESS<br><b>500 UNIVERSITY BLVD., W. SILVER SPRING, MD.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 09 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Brady</b>  |  |

MEDICAL CERTIFICATION

4300 BP



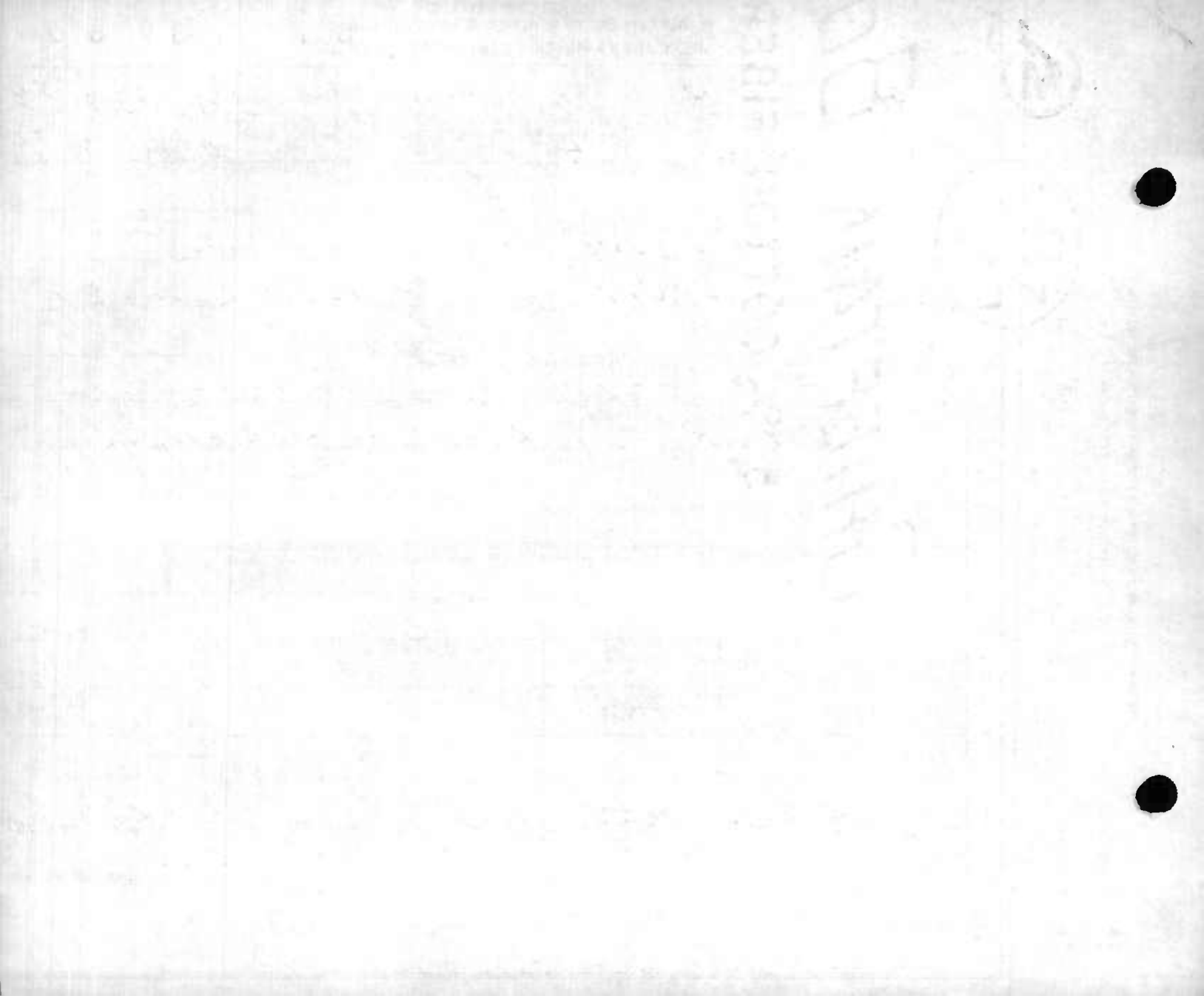
*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17 20M 1/73  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |                                  |  |   |  |  |  |  | REG. NO. 10960                               |  |
|---|------------------|---|----------------------------------|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Albert R Montillo</b>   |                  |   |                                  |  |   |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>April 2, 1981</b> |  |
| 3. SEX <b>M</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>Sept. 13, 1923</b>  | 6. AGE (IN YEARS) <b>57</b> YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD <b>April 2, 1981</b>  |  | 7d. HOUR <b>5:22</b> PM  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>                               |  | MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>P.O. Spg.</b>  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp.</b> |                                  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Jeweler Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>MD</b>  |                  |   |                                  | 13b. COUNTY <b>Mont.</b>   |   | 13c. CITY OR TOWN <b>P.O. Spg.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME <b>Anthony Montillo</b>   |                  |   |                                  | 15. MOTHER'S MAIDEN NAME <b>Emily Aruta</b>  |   | 13e. STREET ADDRESS <b>12710 Louvie Dr.</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |                  | (IF YES, GIVE WAR OR DATES) <b>WWII</b>   |                                  | 16b. SOCIAL SECURITY NO. <b>087 16 4644</b>  |   | 17. INFORMANT ADDRESS <b>M. Jane Montillo (Wife) Same as above</b>                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Abdom. Aortic Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |                  |   |                                  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>  |                  |   |                                  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                  |  |   |  |  | 70. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |   |                                  |  |   |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>  |                  | TITLE (SPECIFY) <b>M.D.</b>   |                                  | MEDICAL EXAMINER   |   | DATE SIGNED <b>Apr. 12, 1981</b>   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>   |                  | ADDRESS <b>1919 Seminary Rd. S.S.Md.</b>  |                                  |  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |                  | 23b. DATE <b>4/3/81</b>   |                                  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>                      |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b>   |                  |   |                                  | ADDRESS <b>11800 N.H. Ave. S.S.Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>APR 6 1981</b>                                      |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |

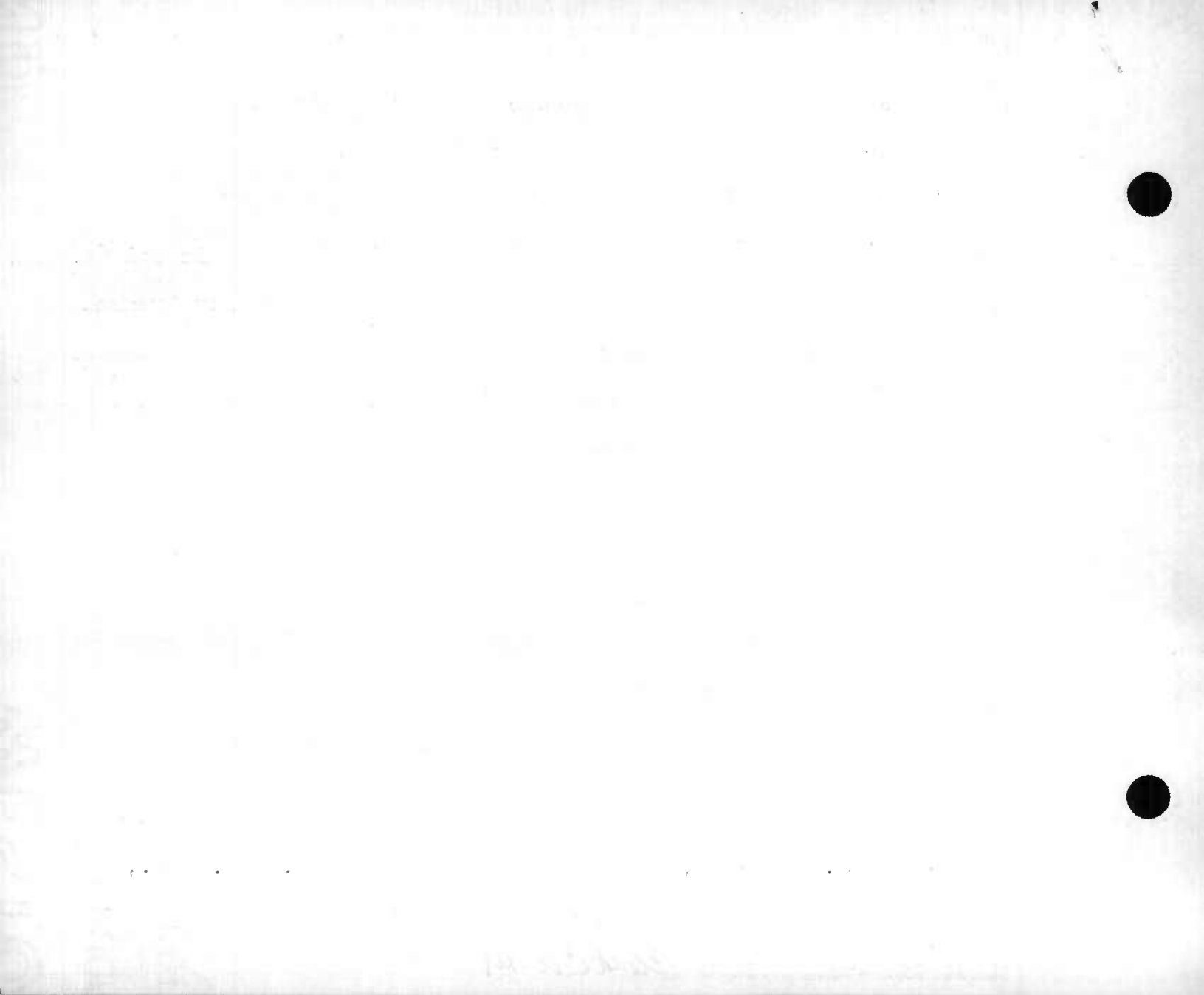


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 0 9 6 1   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| Mary E. Moore   |  |  |  | April 14, 1981 4:30 A.M.  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Feb. 12 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>D.C. School Teacher   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland  |  | 13c. CITY OR TOWN<br>Montgomery Sil. Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>10001 McKenney Avenue,  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Wallace Johnston  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Amanda Hibbard  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>220-44-2147-T  |  |
| 17. INFORMANT<br>(son)  |  | 18. ADDRESS<br>1101 Highland Ave.  |  | 19. CITY OR TOWN<br>S.S. Md.  |  | 20. STATE<br>Md.   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebral Ischemia</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CVA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 days |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 13</u> , 19 <u>81</u> , to <u>April 14</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>April 13</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Edward J. Richards</u>   |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>4-14-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edward J. Richards, MD   |  |  |  | 22e. ADDRESS<br>10301 Georgia Ave. Sil. Spr., MD 20902  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4-17-1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland Pr. Georges Md.   |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
| REG. NO.   |  |   |  |   |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THELMA L. MORGAN</b>  |  |   |  |   |   | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  |
|  |  |   |  |   |   | 4   |  | 28 81  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 14 1912</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Govt</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montg</b>   |  | 13c. CITY OR TOWN<br><b>Kensington</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3503 Murdock Rd</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emmett Jacobs</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Winfield</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>579-03-478</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Margaret J Busching</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |   |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |   |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>Cardiac-respiratory arrest</b>  |  |   |  |   |   |   |  |  |  |
| 4280 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |   |   |  |  |  |
| (b) <b>congestive heart failure</b>  |  |   |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |   |   |  |  |  |
| (c)  |  |   |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |  |  |  |
| <b>Chronic &amp; acute renal failure, Cat pulmonale</b>  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> , 19 <b>81</b> , to <b>4/28</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Marian Chung</b>  |  |   |  |   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/28/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARIAN CHUNG</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>344 University Blvd., W. Silver Spring, Md.</b>                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>May 1 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring P.G. Md</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W.W. Chambers Co., Silver Spring Md. 20910</b>  |  |   |  |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1981</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |   |   |  |  |  |

MEDICAL CERTIFICATION

99

BP

10

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

Received of the University of Chicago  
Library  
for the use of the  
Department of Chemistry  
the sum of \$100.00  
March 10, 1910

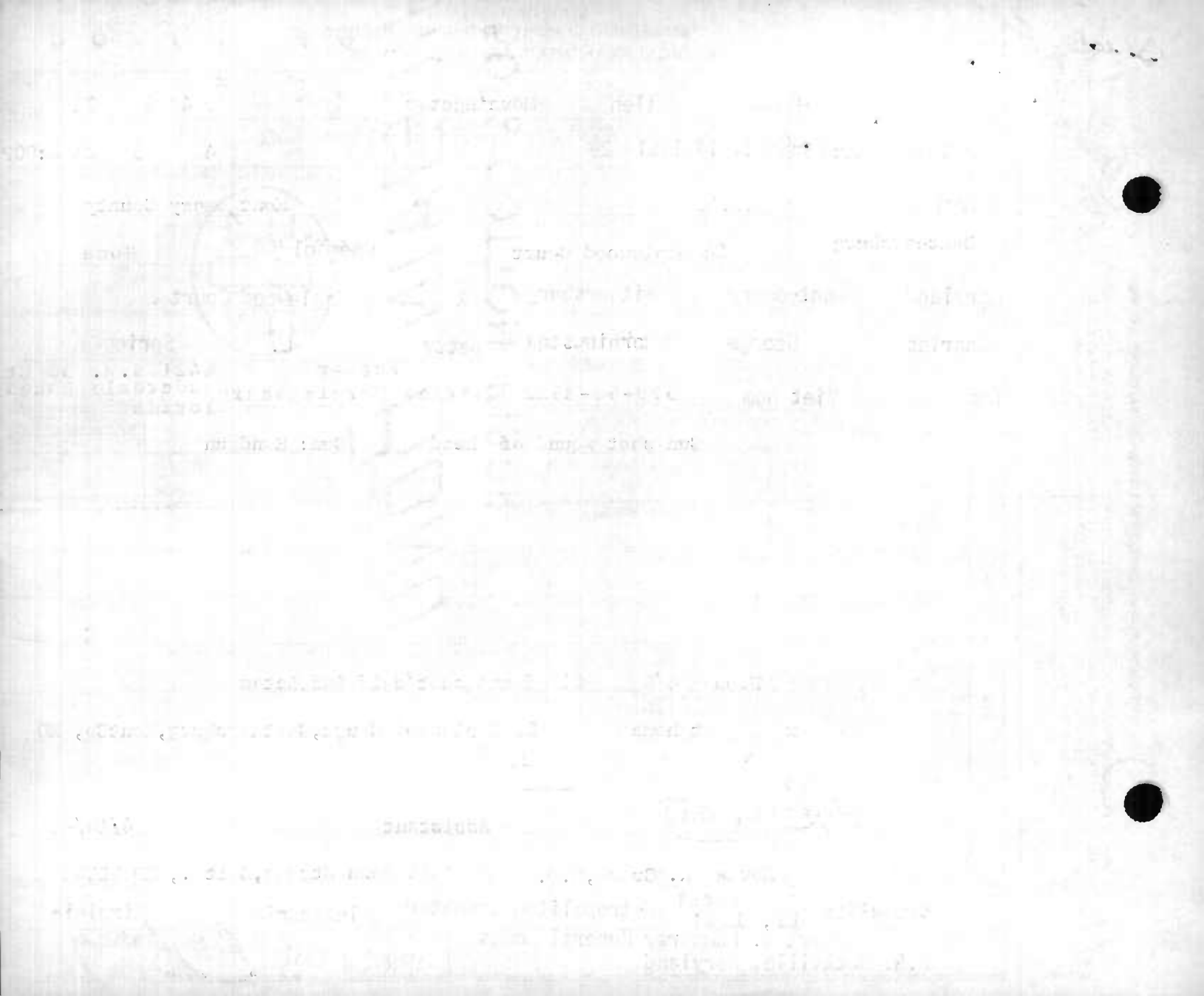
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR 15 ME (5))  
15M 2/80

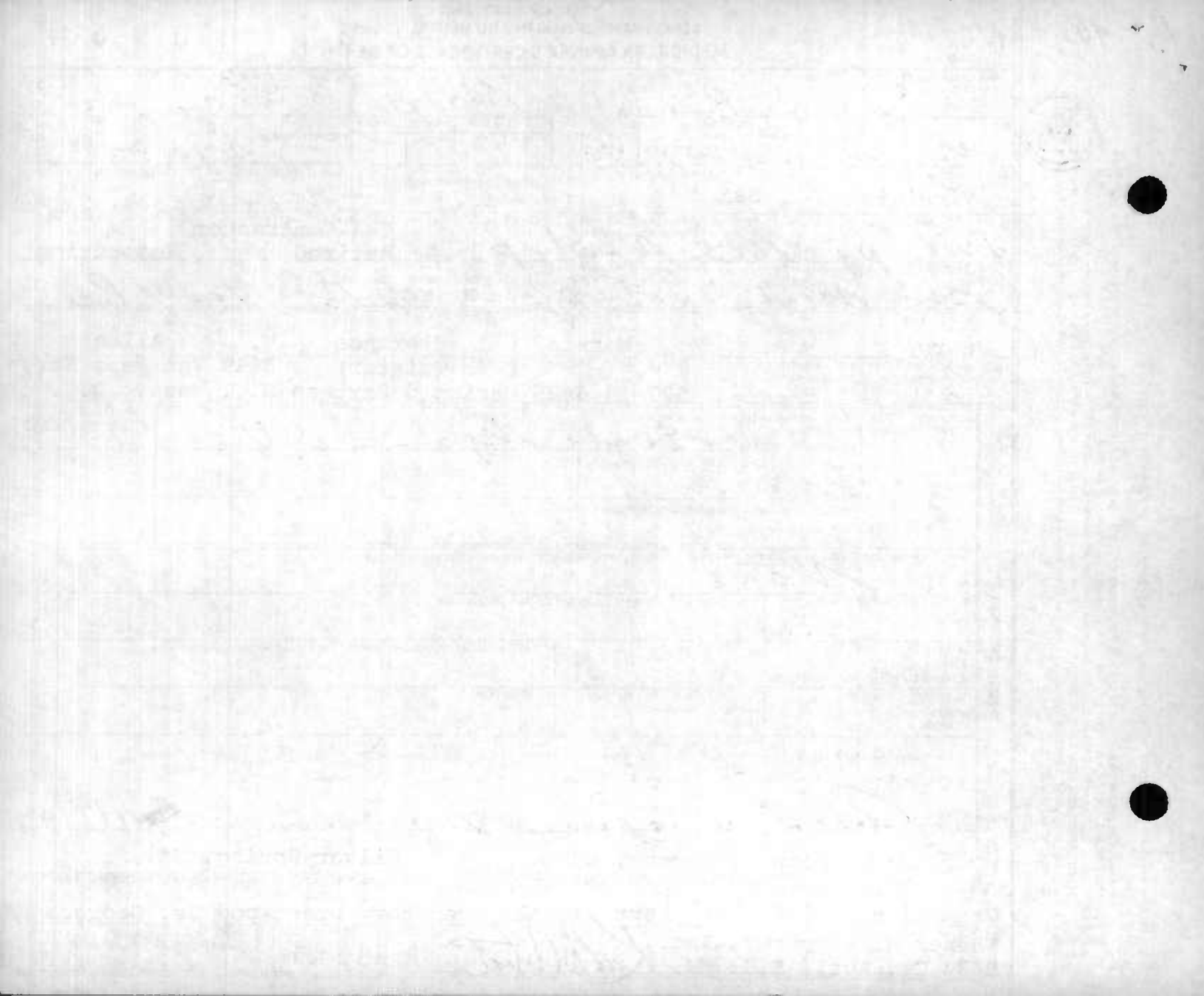
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |   |   |   |   | REG. NO. 10963  |   |                              |                              |  |
|--|--|----------------------|--|--|--|---|---|---|---|---|---|------------------------------|------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |                      | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST<br>Glenn Allen Morningstar  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED                          |   | MONTH DAY YEAR<br>4 8 1981                |                              | 2b. HOUR<br>AM PM<br>6:00 PM |  |
| 3. SEX<br>male   |  | 4. RACE<br>Caucasian |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 14, 1951 |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>29   |   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                    |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 8 1981                              |   | 2d. HOUR<br>AM PM<br>6:00 PM |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD. |   |   |                              |                              |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg  |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>24 Maplewood Court |  |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>None |                              |                              |  |
| 13a. STATE<br>Maryland   |  |                      | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Gaithersburg                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>24 Maplewood Court.                    |   |   |                              |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles George Morningstar   |  |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Betty L. Spring   |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes Viet Nam  |   |   |   |   |   |                              |                              |  |
| 16a. SOCIAL SECURITY NO.<br>579-68-3522  |  |                      | 17. INFORMANT<br>Father Charles Morningstar  |  |  |   |   |   |   | ADDRESS<br>4421 N.W. 36 Ct<br>Lauderdale Lakes<br>Florida                           |   |                              |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> <u>Gun: Handgun</u><br>9550<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |                      |  |  |  |   |   |   |   |   |   |                              |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                      |  |  |  |   |   |   |   |   |   |                              |                              |  |
| 19a. DATE OF OPERATION   |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                              |                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>Noon P.M. 4/8 1981  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>found shot/self inflicted  |   |   |   |   |   |                              |                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>at home   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>25 Maplewood Court, Gaithersburg, MontCo, MD   |   |   |   |   |   |                              |                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |   |   |   |   |   |                              |                              |  |
| ACTUAL SIGNATURE<br><i>H. Guard</i>  |  |                      | TITLE (SPECIFY)<br>M.D. Assistant  |  |  | MEDICAL EXAMINER  |   |   | DATE SIGNED<br>4/10/81  |   |   |                              |                              |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |  |                      | ADDRESS<br>111 Penn Street, Balto., MD 21201   |  |  |   |   |   |   |   |   |                              |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |                      | 23b. DATE<br>April 11, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria Virginia           |   |   |   |                              |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes,<br>P.A. Rockville, Maryland  |  |                      | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Pumphrey</i>   |   |   |   |   |   |                              |                              |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 10964  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Edwin Randolph Morris</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>April 1981</b>   |  |
| 2. SEX <b>M</b> 3. RACE <b>W</b> 4. DATE OF BIRTH <b>Nov 25 1907</b> 5. AGE IN YEARS <b>73</b> 6. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN.  |  |  |  |  |  |  |  |  |  | 2b. DATE PRONOUNCED DEAD <b>April 19 81</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Spa</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1613 Neely Rd.</b> 12a. USUAL OCCUPATION (TYPE OF WORK) <b>Contractor</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>   |  |  |  |  |  |  |  |  |  | 12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>1613 Neely Rd.</b> |  |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>Mont.</b> 13c. CITY OR TOWN <b>Spa</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1613 Neely Rd.</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME (TYPE OR PRINT) <b>Henry R. Morris</b> 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Florence V. Allen</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b> 16b. SOCIAL SECURITY NO. <b>577-10-8426</b> 17. INFORMANT (NAME AND ADDRESS) <b>Marion deHartman-N.W. Wash., D.C.</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b><br>4291<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>                                |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>P.M.</b> 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Silver Spring, Md.</b> 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. <b>Dep</b> MEDICAL EXAMINER DATE <b>April 19 81</b>  |  |  |  |  |  |  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b> ADDRESS <b>Silver Spring, Md.</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b> 23b. DATE <b>4-10-1981</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Georges Md</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b> 25a. DATE REC'D. BY REGISTRAR <b>APR 13 1981</b> 25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>   |  |  |  |  |  |  |  |  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |
|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 8 1 1 0 9 6 5   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rose Moulton   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 20, 1981   |  |
| 3 SEX<br>Female   |  | 2b. HOUR<br>9:20 <sup>A</sup>   |  |
| 4 RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 27 1891  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Potomac Valley Nursing Home  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  |
| 13c. CITY OR TOWN<br>Bethesda/  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Madison Sallade   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara Not Available  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>579-22-6929   |  |
| 17. INFORMANT<br>ADDRESS<br>Elizabeth M. Bamel (See item # 13)  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>PNON MORTIS</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ORGANIC BRAIN SYNDROME</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Generalized Anterior Sclerosis</i>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Generalized Anterior Sclerosis</i>  |  |   |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> 19 <i>77</i> to <i>4-20</i> 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>3-22</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><i>Roland Imperial</i>  |  | 22c. DATE SIGNED<br><i>April 20, 1981</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Roland Imperial, M.D.  |  | 22e. ADDRESS<br>4977 Battery Lane Bethesda, Maryland  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>April 21, 1981   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>ROBERT A. PUMPHREY FUNERAL<br>HOMES, P.A., BETHESDA, MARYLAND   |  | 25. DATE REC'D. BY REGISTRAR<br>APR 24 1981   |  |
| 26. REGISTRAR'S SIGNATURE<br><i>Jeffrey H. Hardy</i>  |  |   |  |

17

1028 S. H. A.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | REG. NO.   |  |
| MAURY  |  | MURIK  |  | 4-6-81   |  | 8 <sup>35</sup> PM   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7b. HOUR   |  |
| MALE   | WHITE  | 2 26 19  |  | 62 YRS   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| GERMANY  | U.S.A.   |  |  | MONTGOMERY COUNTY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. DEPARTMENT OR STORE                                       |  |
| SILVER SPRING  | HOLY CROSS HOSPITAL  |  |  | TAILOR   |  |  |  |
| 13a. STATE   |  |  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS  |  |
| MARYLAND   |  | MONTGOMERY   |  | SILVER SPRING  |  | 2401 ESTHER COURT  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
| NAPHTALI   |  | MURIK  |  | (UNASCERTAINABLE) (UNASCERTAINABLE)  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| NO   |  | 579-40-5760  |  | MANDZIA MURIK, same as #13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) Cardiac Arrest   |  |  |  |  |  | 1 hr   |  |
| 4/10 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction  |  |  |  |  |  | 6 hrs  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease   |  |  |  |  |  | 20 yrs   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/6 81 to 4/1 81, to 4/6 81, that (I) (we) last saw the deceased alive on 4/6 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, so state) (Do not check view the back after death.) |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATES SIGNED  |  |
| RALPH E. SELIGMANN   |  |  |  | MD   |  | 4/6/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| RALPH E. SELIGMANN   |  |  |  | 8630 FENTON ST. SILVER SPRING, MD. 2091  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| BURIAL   |  | 4/8/1981   |  | KESHER ISRAEL CONGREGATION CEMETERY  |  | WASHINGTON D. C.   |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25. DATE REC'D BY REGISTRAR  |  | 26. REGISTRAR'S SIGNATURE                                      |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |  |  | APR 10 1981  |  | [Signature]  |  |



APR 10 1981

*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

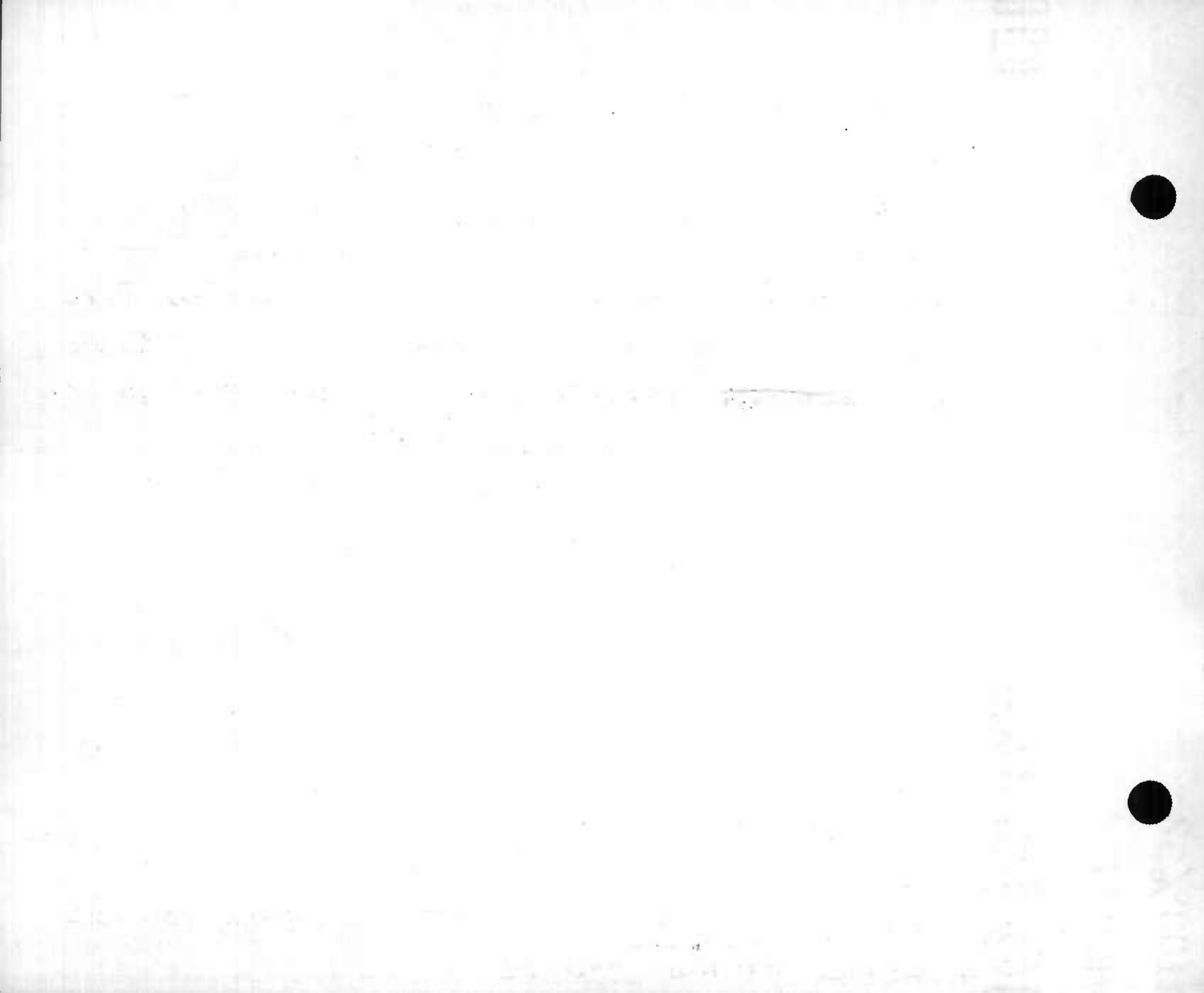
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81

10967

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY MARGARET MURPHY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-16-81</b>                |  | 2b. HOUR<br>MIN<br><b>11A</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 2, 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. DC.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>MONT.</b>  | 13c. CITY OR TOWN<br><b>POTOMAC</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William CANNON</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY - Burke</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>57952 5672</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. MARY M. DUGAN #13 (DAUGHTER)</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic obstructive pulmonary disease</b><br>10 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1979</b> to <b>Apr 16, 1981</b> , that (I) (we) last saw the deceased alive on <b>April 15, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <b>above (I) (we) did (did not) view the body after death.</b>   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. E. Fitzgerald M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/16/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. E. FITZGERALD M.D.</b>   |  | 22e. ADDRESS<br><b>3800 Reservoir RD. NW WASH. DC</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>APR 20 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET</b>                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WASHINGTON, DC</b>   |  | 25a. DATE REG. BY REGISTRAR<br><b>APR 20 1981</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W.W. ALTAVOL</b>   |  | ADDRESS<br><b>4748 Wisc. Ave. NW, Wash. DC</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VRA 15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Susan

M.

Musselwhite

2. SEX

Female

4. RACE

White

5. DATE OF BIRTH  
MONTH DAY YEAR  
Mar. 14, 18886. AGE (IN YEARS  
LAST BIRTHDAY)  
93 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2a. DATE KNOWN  
OF ESTI-  
DEATH MATEDMONTH DAY YEAR  
4/10 19 812b. HOUR  
3:59 P. M.7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD.

10. CITY OR TOWN OF DEATH

Takoma Park

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS  
OR INDUSTRY

U.S. Govt.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Virginia Arlington Heights

13a. STATE

COUNTY

XXXXXXX

13b. INSIDE CITY LIMITS?

YES ☒ NO ☐

13c. STREET ADDRESS

2200 Col. Pike,

14. FATHER'S NAME

FIRST

MIDDLE

LAST

John

Harvey

Musselwhite

15. MOTHER'S MAIDEN NAME

Susan

MIDDLE

LAST

V.

Poston

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

577-52-2917

17. INFORMANT

(\$ister) 400 Hindsdale Lane,

Sarah Slaird-S.S. Md. 20901

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypovolemic shock.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Fracture of left hip.

19a. DATE OF OPERATION

2/2 &amp; 3/2/81

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

Fracture of left hip.

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☒ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 2/1 1981

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Fell at home.

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME

STREET, FACTORY, FARM, ETC.)

Home

21i. LOCATION

CITY OR TOWN COUNTY STATE  
Hinsdale Lane, Silver Spring, Montgomery, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion  
death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D. Deputy MEDICAL EXAMINER

DATE  
SIGNED 4/13/81EXAMINER'S NAME  
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

1919 Seminary Road  
Silver Spring, Montgomery, Md.23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

4-13-1981

23c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven

23d. LOCATION  
CITY OR TOWN

Sil. Spring Montgomery Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

Warner E. Pumphrey, Inc.

25a. DATE REC'D. BY REGISTRAR

APR 16 1981

25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

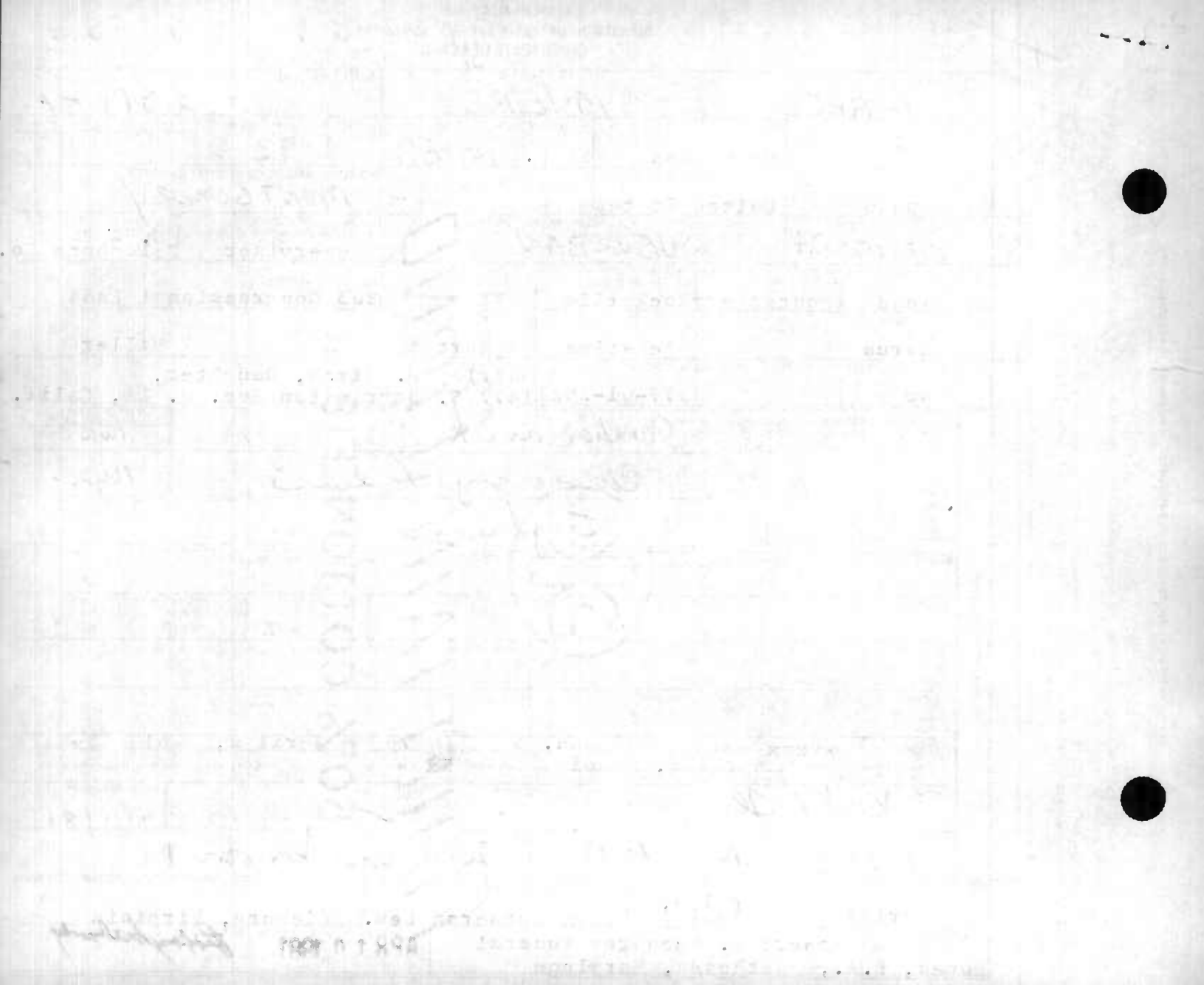
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |  |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GRACE E MYERS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>3</b> YEAR <b>81</b>    |   |   | 2b. HOUR<br><b>5 A M</b>   |  |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>15</b> YEAR <b>07</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Telephone Co.</b>  |  |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |   |  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS<br><b>263 Congressional Lane</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Cyrus</b> MIDDLE <b></b> LAST <b>Eckstine</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Martha</b> MIDDLE <b></b> LAST <b>Miller</b>   |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>577-01-2621</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Shirley M. Birch, Daughter,<br/>1477 S. Barrington Ave. W. LA. Calif.</b> |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4920</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic hyp failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Emphysema</b>   |  |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                           |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (the physician) attended the deceased from <b>Jan. 5</b> , 19 <b>76</b> , to <b>April 2</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 2</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Kirk E Flum</b>   |  |  |  |   |   | DEGREE   |  | 22c. DATE SIGNED<br><b>4/4/81</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KIRK E FLUM M.D.</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>9410 Old Georgetown Rd</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>April 8, 1981</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Lutheran Cem.</b> |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Edinburg</b> COUNTY <b>Virginia</b> STATE <b></b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Homes, P.A., Bethesda, Maryland</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1501

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8110970   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR   |  |  |  |
| Susanna V. Myers  |  |  |  | April 19, 1981 9:00 p M  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female  |  | White  |  | 9 7 82   |  | 98 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Chester, Penna.   |  | USA  |  |  |  | Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Silver Spring   |  | 11235 Oak Leaf Drive, apt 1010   |  | Housewife  |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  |  |  |
| Maryland  |  |  |  | Montgomery   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| Edgar W Stevenson   |  |  |  | Susanna Rowen  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |
| No  |  |  |  | 577-42-8525A   |  |  |  |
| 17. INFORMANT ADDRESS   |  |  |  | 17. INFORMANT ADDRESS  |  |  |  |
| 11235 Oak Leaf Dr, apt 1010   |  |  |  | Eloise Whitmer Silver Spring, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 4289  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Failure</u>   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | 19   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|   |  |  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 24</u> 19 <u>79</u> to <u>April 19</u> 19 <u>81</u> , that (we) lost saw the deceased alive on <u>April 17</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22a. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <u>Frank C. Blackburn</u>   |  |  |  |  |  | <u>April 20, 1981</u>  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22d. ADDRESS   |  |  |  |
| Frank C. Blackburn  |  |  |  | 5401 Western Ave, N.W. Washington, D.C. 20015  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 4-24-81  |  | Chester Rural Cem.   |  | Chester Delaware Pennsylvania                                  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25. ADDRESS  |  |  |  |
| Hines/Rinaldi F.H./   |  |  |  | 11800 New Hampshire Ave Silver Spring, Md.   |  |  |  |





## Medical Examiner Notified &amp; Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |  |  |  |
|--|--|--|---|---|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |   |   | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Irene M. Nash</b>  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 9, 1981</b>  |  |   | 2b. HOUR<br><b>05:10 A</b>   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 8, 1891</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |   |   | 13b. CITY OR TOWN<br><b>P.G.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>6802 Pineway</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William T. Arthur</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lena Schreiber</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>215-26-3504</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Herman L. Neugass Apt-924-E. Wash. D.C.</b>                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured abdominal Aortic Aneurysm.</b><br>4413<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Diffuse advanced Atherosclerotic Cardiovascular</b><br>(c) <b>Disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs.</b><br><b>Undetermined</b> |  |  |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Renal Failure, Hypertension.</b>  |  |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>4/9/81</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured Abdominal Aortic Aneurysm</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 8, 1981</b> to <b>April 9, 1981</b> , that (I) (we) last saw the deceased alive on <b>April 9, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mario H. Diaz MD.</b>   |  |  |   |   | DEGREE<br>MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>4/9/81</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARIO H. DIAZ MD.</b>  |  |  |   |   | 22e. ADDRESS<br><b>1811 Prince Philip Dr. Olney Md.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4-13-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Maryland</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>                                  |   | 25b. REGISTRAR'S SIGNATURE   |  |  |



1981, 5. 4. 81

17

Don't worry

also

Don't worry about the time

Don't worry

Don't worry

Don't worry

Don't worry

Don't worry

Don't worry about the time

Don't worry



1981

1981

1981

1981

1981

Don't worry

Don't worry about the time

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                     |  |  |  |  |  |   |  | REG. NO. 10972   |  |
|--|--|-------------------------------------|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                                     |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William J Nealon  |  |                                     |  |  |  |  |  |   |  | 2b. DATE KNOWN OF DEATH ESTIMATED 4-24-1981                                      |  |
| 3. SEX Male  |  | 4. RACE White                       |  | 5. DATE OF BIRTH MONTH DAY YEAR 12-7-15  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.  |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD 4-24-1981   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH Bethesda   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital                                |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clothing Salesman |  | 12b. KIND OF BUSINESS OR INDUSTRY Clothing                                       |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                     |  |  |  |  |  |   |  |  |  |
| 13a. STATE MD  |  | 13b. COUNTY MONTGOMERY              |  | 13c. CITY OR TOWN Chevy Chase  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET ADDRESS 4701 WILLARD AVE  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Martin Nealon  |  |                                     |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown) Kelly   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |  |                                     |  | 16b. SOCIAL SECURITY NO. 170-09-3494   |  | 17. INFORMANT ADDRESS Josephine G. Nealon, Same address as #13.                                      |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) CORONARY ARTERIOSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                                     |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE                               |  |
| 19a. DATE OF OPERATION   |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                     |  | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 7:45 P.M. 4 24 1981  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) CHEST PAIN + COLLAPSED |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4701 WILLARD AVE BETHESDA MONT MD                     |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion  |  |                                     |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE Francis C. Mayhew   |  |                                     |  | TITLE (SPECIFY) Dept 4   |  |  |  | DATE SIGNED 4/24/81   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYHEW   |  |                                     |  | ADDRESS 8200 Wisconsin Ave Bethesda MD   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |                                     |  | 23b. DATE 4/29/81  |  | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Kingston, New York                      |  |  |  |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016  |  |                                     |  |  |  | 25a. DATE REC'D. BY REGISTRAR APR 29 1981  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 10973  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR  |  |
| Edward Robert Nelson  |  |   |  | April 19, 1981   |  |  |  | 2:30 P  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                           |  |
| Male  |  | White   |  | July 6, 1926   |  | 54 YRS.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Pennsylvania  |  | United States   |  |  |  | Montgomery County MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Bethesda  |  | Clinical Center, Bethesda, Md.  |  |  |  | Chemist  |  | U.S. Govt.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. INSIDE CITY LIMITS?   |  | 13b. STREET ADDRESS  |  |   |  |
| 13a. STATE  |  |   |  | 13c. CITY OR TOWN  |  | 13b. STREET ADDRESS  |  |   |  |
| Maryland  |  |   |  | Montgomery Bethesda  |  | 5201 Roosevelt St. 20014   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |  |   |  |
| Edward Albert Nelson  |  |   |  | Anna Garey   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |
| Yes   |  |   |  | WWII   |  | Nelson<br>Anne B. 617 Essex St. Mass.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| IMMEDIATE CAUSE (a) HYPOTENSION-CARDIAC ARREST  |  |   |  |  |  |  |  |   |  |
| 1350<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) SARCROIDOSIS   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |   |  |
| RENAL FAILURE   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  |
|   |  |   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
|   |  |   |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
|   |  |   |  |  |  |  |  |   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from March 3, 1981, to April 19, 1981, that (x) (we) lost saw the deceased alive on April 19, 1981, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above, (y) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |
| Margaret M. Parker MD   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |  | 4/20/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |  |  |   |  |
| Margaret M. Parker MD   |  |   |  | National Institutes of Health<br>Clinical Center, Bethesda, Md. 20205  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |  |   |  |
| Cremation   |  | April 21, 1981  |  | Metropolitan Crem.   |  | Alexandria, Virginia   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | 25a. DATE REG'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Robert A. Pumphrey Funeral Homes P.A. Bethesda, Maryland 20014  |  |   |  | APR 24 1981  |  |  |  |   |  |

1907 2 2 494



BH

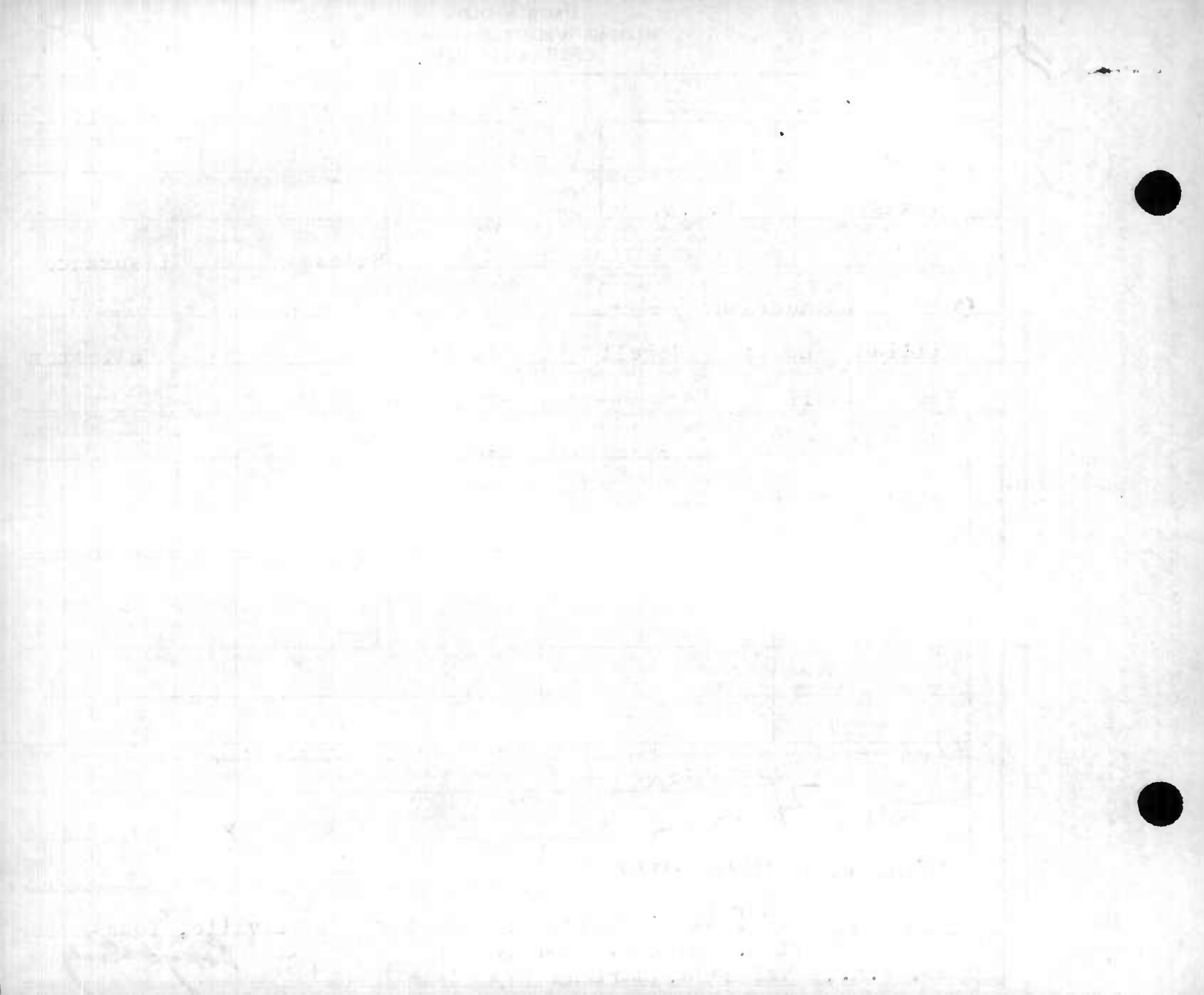
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. 8110974            |       |  |
|---|--|---|--|---|--|---|--|--|--|-----------------------------|-------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>J. ALVIN NEWELL   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 13, 1981  |  |  | 2b. HOUR<br>11:15pm                            |                             |       |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JAN 17, 1913   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN. |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Texas  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.                                   |  |  |  |                             |       |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE CLINICAL CENTER |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman                       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance |                             |       |  |
| 13a. STATE<br>TEXAS   |  | 13b. COUNTY<br>Henderson  |  | 13c. CITY OR TOWN<br>MABANK   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>116 LARK DR   |  |                             | 75147 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Lewis Newell   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Julia McAlester   |  |   |  |  |  |                             |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WWII  |  | 17. INFORMANT<br>MRS. MARY NEWELL   |  | ADDRESS<br>SAME AS ABOVE  |  |  |  |                             |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Esophageal Cancer</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |   |  |  |  |                             |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |  |  |  |                             |       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                             |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                             |       |  |
| 22a. I certify that <del>we</del> (this hospital) attended the deceased from <u>FEBRUARY 27</u> 19 <u>81</u> , to <u>APRIL 13</u> , 19 <u>81</u> , that <del>we</del> (we) lost saw the deceased alive on <u>APRIL 13</u> 19 <u>81</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>or</del> (we) (did) <del>not</del> view the body after death. |  |   |  |   |  |   |  |  |  |                             |       |  |
| 22b. SIGNATURE<br><i>Julian B. Hill, MD</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>4/14/81  |  |                             |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Julian B. Hill, MD   |  |   |  | 22e. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MD 20205  |  |   |  |  |  |                             |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>April 16, 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Huntsville Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Huntsville, Texas                                 |  |  |  |                             |       |  |
| 24. FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Pumphrey</i>   |  |  |  |                             |       |  |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 10975

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Pearl W Missenbaum   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 12, 1981   |  | 2b. HOUR<br>9:40 P.M.  |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 19, 1891  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ga.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5480 Wisc. Ave. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Md.   |  | 13b. CITY OR TOWN<br>Chevy Chase   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>5480 Wisc. Ave.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Isador Winer  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hannah Lafkowitz  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>578-46-1887  | 17. INFORMANT<br>ADDRESS<br>Helene N. Devay 5101 River Rd. C.C. Md.                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) congestive heart failure<br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from July 1, 19 71, to 4-12 19 81, that (1) we last saw the deceased alive on 4-8 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.  |  |  |   |  |  |
| 22b. SIGNATURE<br>James H. Brodsky  |  | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>4/12/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James H. Brodsky   |  | 22e. ADDRESS<br>4701 Willard Ave., Chevy Chase, Md.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>4.14/81   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons, Inc.<br>5130 Wisc. Ave. N.W., Wash., D.C.   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981   |   | 25b. SIGNATURE<br>[Signature]  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

released at the conversation Dr. W. H. 4-12-81

1995-1996 2.8

225 05 10

• DV •

• 07/24/10 •

2

•

•

2000

1974-1975 (1976) 1976-1977 (1977) 1977-1978 (1978) 1978-1979 (1979) 1979-1980 (1980) 1980-1981 (1981) 1981-1982 (1982) 1982-1983 (1983) 1983-1984 (1984) 1984-1985 (1985) 1985-1986 (1986) 1986-1987 (1987) 1987-1988 (1988) 1988-1989 (1989) 1989-1990 (1990) 1990-1991 (1991) 1991-1992 (1992) 1992-1993 (1993) 1993-1994 (1994) 1994-1995 (1995) 1995-1996 (1996) 1996-1997 (1997) 1997-1998 (1998) 1998-1999 (1999) 1999-2000 (2000) 2000-2001 (2001) 2001-2002 (2002) 2002-2003 (2003) 2003-2004 (2004) 2004-2005 (2005) 2005-2006 (2006) 2006-2007 (2007) 2007-2008 (2008) 2008-2009 (2009) 2009-2010 (2010) 2010-2011 (2011) 2011-2012 (2012) 2012-2013 (2013) 2013-2014 (2014) 2014-2015 (2015) 2015-2016 (2016) 2016-2017 (2017) 2017-2018 (2018) 2018-2019 (2019) 2019-2020 (2020) 2020-2021 (2021) 2021-2022 (2022) 2022-2023 (2023) 2023-2024 (2024) 2024-2025 (2025) 2025-2026 (2026) 2026-2027 (2027) 2027-2028 (2028) 2028-2029 (2029) 2029-2030 (2030) 2030-2031 (2031) 2031-2032 (2032) 2032-2033 (2033) 2033-2034 (2034) 2034-2035 (2035) 2035-2036 (2036) 2036-2037 (2037) 2037-2038 (2038) 2038-2039 (2039) 2039-2040 (2040) 2040-2041 (2041) 2041-2042 (2042) 2042-2043 (2043) 2043-2044 (2044) 2044-2045 (2045) 2045-2046 (2046) 2046-2047 (2047) 2047-2048 (2048) 2048-2049 (2049) 2049-2050 (2050) 2050-2051 (2051) 2051-2052 (2052) 2052-2053 (2053) 2053-2054 (2054) 2054-2055 (2055) 2055-2056 (2056) 2056-2057 (2057) 2057-2058 (2058) 2058-2059 (2059) 2059-2060 (2060) 2060-2061 (2061) 2061-2062 (2062) 2062-2063 (2063) 2063-2064 (2064) 2064-2065 (2065) 2065-2066 (2066) 2066-2067 (2067) 2067-2068 (2068) 2068-2069 (2069) 2069-2070 (2070) 2070-2071 (2071) 2071-2072 (2072) 2072-2073 (2073) 2073-2074 (2074) 2074-2075 (2075) 2075-2076 (2076) 2076-2077 (2077) 2077-2078 (2078) 2078-2079 (2079) 2079-2080 (2080) 2080-2081 (2081) 2081-2082 (2082) 2082-2083 (2083) 2083-2084 (2084) 2084-2085 (2085) 2085-2086 (2086) 2086-2087 (2087) 2087-2088 (2088) 2088-2089 (2089) 2089-2090 (2090) 2090-2091 (2091) 2091-2092 (2092) 2092-2093 (2093) 2093-2094 (2094) 2094-2095 (2095) 2095-2096 (2096) 2096-2097 (2097) 2097-2098 (2098) 2098-2099 (2099) 2099-2100 (2100) 2100-2101 (2101) 2101-2102 (2102) 2102-2103 (2103) 2103-2104 (2104) 2104-2105 (2105) 2105-2106 (2106) 2106-2107 (2107) 2107-2108 (2108) 2108-2109 (2109) 2109-2110 (2110) 2110-2111 (2111) 2111-2112 (2112) 2112-2113 (2113) 2113-2114 (2114) 2114-2115 (2115) 2115-2116 (2116) 2116-2117 (2117) 2117-2118 (2118) 2118-2119 (2119) 2119-2120 (2120) 2120-2121 (2121) 2121-2122 (2122) 2122-2123 (2123) 2123-2124 (2124) 2124-2125 (2125) 2125-2126 (2126) 2126-2127 (2127) 2127-2128 (2128) 2128-2129 (2129) 2129-2130 (2130) 2130-2131 (2131) 2131-2132 (2132) 2132-2133 (2133) 2133-2134 (2134) 2134-2135 (2135) 2135-2136 (2136) 2136-2137 (2137) 2137-2138 (2138) 2138-2139 (2139) 2139-2140 (2140) 2140-2141 (2141) 2141-2142 (2142) 2142-2143 (2143) 2143-2144 (2144) 2144-2145 (2145) 2145-2146 (2146) 2146-2147 (2147) 2147-2148 (2148) 2148-2149 (2149) 2149-2150 (2150) 2150-2151 (2151) 2151-2152 (2152) 2152-2153 (2153) 2153-2154 (2154) 2154-2155 (2155) 2155-2156 (2156) 2156-2157 (2157) 2157-2158 (2158) 2158-2159 (2159) 2159-2160 (2160) 2160-2161 (2161) 2161-2162 (2162) 2162-2163 (2163) 2163-2164 (2164) 2164-2165 (2165) 2165-2166 (2166) 2166-2167 (2167) 2167-2168 (2168) 2168-2169 (2169) 2169-2170 (2170) 2170-2171 (2171) 2171-2172 (2172) 2172-2173 (2173) 2173-2174 (2174) 2174-2175 (2175) 2175-2176 (2176) 2176-2177 (2177) 2177-2178 (2178) 2178-2179 (2179) 2179-2180 (2180) 2180-2181 (2181) 2181-2182 (2182) 2182-2183 (2183) 2183-2184 (2184) 2184-2185 (2185) 2185-2186 (2186) 2186-2187 (2187) 2187-2188 (2188) 2188-2189 (2189) 2189-2190 (2190) 2190-2191 (2191) 2191-2192 (2192) 2192-2193 (2193) 2193-2194 (2194) 2194-2195 (2195) 2195-2196 (2196) 2196-2197 (2197) 2197-2198 (2198) 2198-2199 (2199) 2199-2200 (2200) 2200-2201 (2201) 2201-2202 (2202) 2202-2203 (2203) 2203-2204 (2204) 2204-2205 (2205) 2205-2206 (2206) 2206-2207 (2207) 2207-2208 (2208) 2208-2209 (2209) 2209-2210 (2210) 2210-2211 (2211) 2211-2212 (2212) 2212-2213 (2213) 2213-2214 (2214) 2214-2215 (2215) 2215-2216 (2216) 2216-2217 (2217) 2217-2218 (2218) 2218-2219 (2219) 2219-2220 (2220) 2220-2221 (2221) 2221-2222 (2222) 2222-2223 (2223) 2223-2224 (2224) 2224-2225 (2225) 2225-2226 (2226) 2226-2227 (2227) 2227-2228 (2228) 2228-2229 (2229) 2229-2230 (2230) 2230-2231 (2231

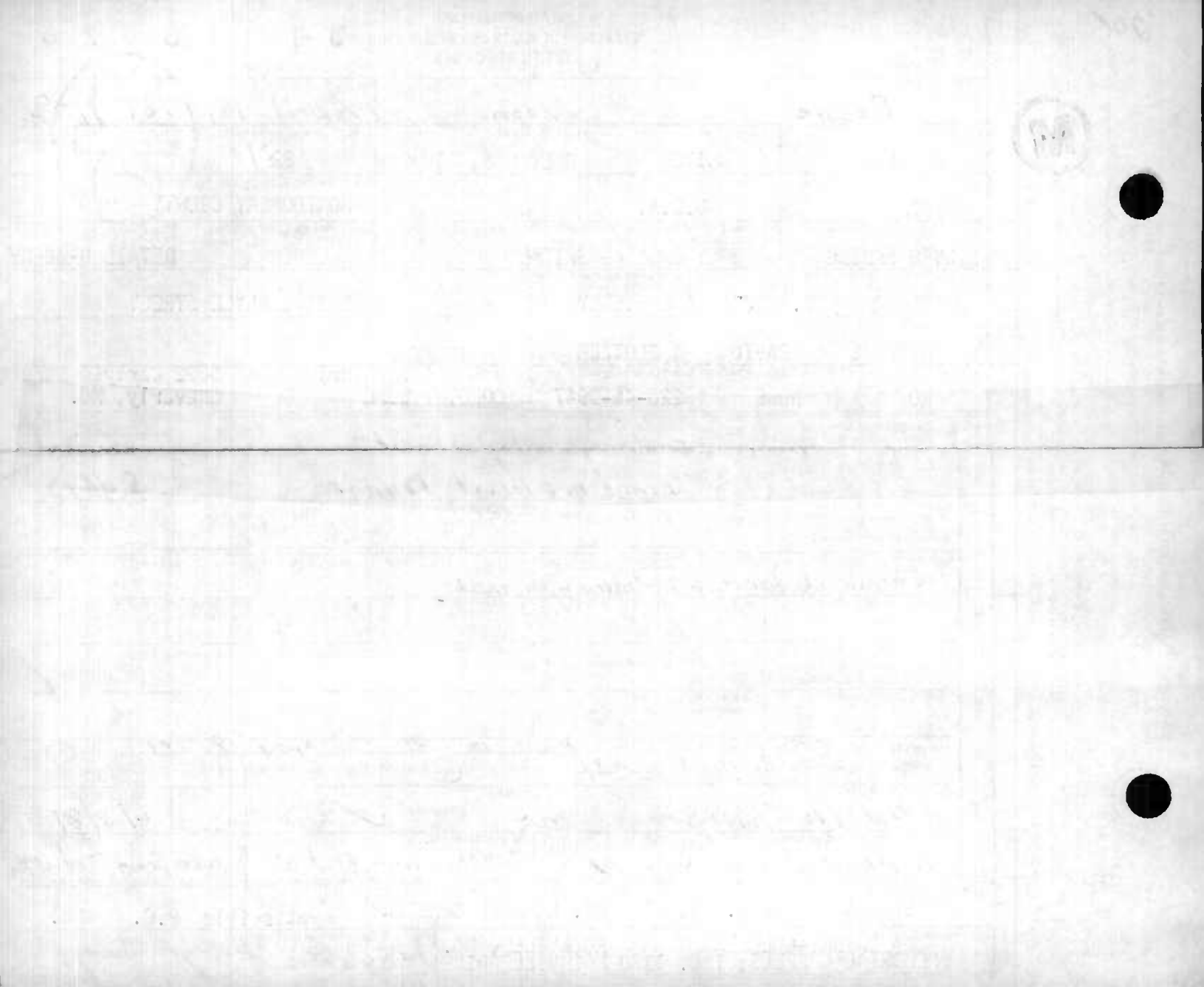
• 5 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |   |  | 8 1 1 0 9 7 6   |                             |                     |                             |  |
|---|--|--|--|---|--|---|--|---|--|---|-----------------------------|---------------------|-----------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |   |  | CERTIFICATE OF DEATH  |                             |                     |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  |   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |                             | 2b. HOUR            |                             |  |
| Bessie Noon   |  |  |  |   |  |   |  |   |  | April 18, 1981  |                             | 11:30 AM            |                             |  |
| 3 SEX   |  |  | 4 RACE   |   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |   | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR MONTHS DAYS |                     | IF UNDER 24 HRS. HOURS MIN. |  |
| FEMALE  |  |  | WHITE  |   |  | JULY 5, 1898  |  |   | 82 YRS.  |   |                             |                     |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |                             |                     |                             |  |
| RUSSIA  |  |  | U.S.A.   |   |  |   |  |   | MONTGOMERY COUNTY MD.  |   |                             |                     |                             |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                             |                     |                             |  |
| SILVER SPRING   |  |  | HOLY CROSS HOSPITAL  |   |  | OWNER   |  |   | RETAIL GROCERY   |   |                             |                     |                             |  |
| 13a. STATE  |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN   |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                             | 13e. STREET ADDRESS |                             |  |
| MARYLAND  |  |  | PR. GEORGE   |   |  | CHEVERLY  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |   |                             | 5822 CARLYLE STREET |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |  |   |  |   |  |   |                             |                     |                             |  |
| MICHAEL DAVID GLOTZER   |  |  | UNKNOWN  |   |  |   |  |   |  |   |                             |                     |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |   |  | 17. INFORMANT (Daughter)  |  |   | ADDRESS  |   |                             |                     |                             |  |
| NO  |  |  | NONE   |   |  | 226-46-9947   |  |   | 5822 Carlyle Street Cheverly, Md.  |   |                             |                     |                             |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                             |                     |                             |  |
| 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure  |  |  |  |   |  |   |  |   |  | 8 days  |                             |                     |                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive pulmonary disease   |  |  |  |   |  |   |  |   |  |   |                             |                     |                             |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |                     |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |                             |                     |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |                             |                     |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 10, 1981, to April 18, 1981, that (I) (we) most saw the deceased alive on April 18, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |   |                             |                     |                             |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED  |  |   |                             |                     |                             |  |
| Marian Chung M.D.   |  |  |  | M.D.  |  |   |  | 4/18/81   |  |   |                             |                     |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |  |   |  |   |                             |                     |                             |  |
| MARIAN CHUNG, M.D.  |  |  |  | 344 University Blvd., W. Silver Spring, Md 20901                    |  |   |  |   |  |   |                             |                     |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |                             |                     |                             |  |
| BURIAL  |  |  |  | APR. 21, 81   |  | MT. LEBANON CEMETERY  |  |   |  | Hyattsville P.G. Md.  |                             |                     |                             |  |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG ADDRESS ROCKVILLE, MD. 1170 ROCKVILLE PIKE   |  |  |  |   |  |   |  |   |  |   |                             |                     |                             |  |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |   |  |   |  |   |                             |                     |                             |  |
| APR 24 1981   |  |  |  |   |  |   |  |   |  |   |                             |                     |                             |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 0 9 7 7   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |   |   |
| FIRST MIDDLE LAST<br><b>ALFRED T. O'GRADY</b>  |  |   |  | MONTH DAY YEAR<br><b>4/24/81</b>  |  |   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 15 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ireland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tool &amp; Die Mach.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chrysler Corp.</b>  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?  |  |   |   |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13e. STREET ADDRESS<br><b>121 EVANS STREET</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas O'Grady</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not available.</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>381-03-9894</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mary T. Vieson 121 Evans St., Rockville, Md.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4409 CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIO SCLEROSIS</b>  |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Apr 6</b> 19 <b>81</b> , to <b>Apr 24</b> 19 <b>81</b> , that (I) <del>met</del> lost<br>saw the deceased alive on <b>Apr. 23</b> 19 <b>81</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated<br>(above) (I) <del>examined</del> (did not view the body after death). |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Robert T. Thibaderu</b>   |  |   |  | 22c. DATE SIGNED<br><b>4-24-81</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT T. THIBADERU</b>   |   |
| 22e. ADDRESS<br><b>Rockville Md., 20852</b>  |  |   |  | 22f. DATE REC'D. BY REGISTRAR   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 29 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Sepulchre Cemetery Southfield</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Michigan</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |  |   |  | 25c. DATE REC'D. BY REGISTRAR<br><b>APR 30 1981</b>   |  |   |   |
| 300 W. Montgomery Ave., Rockville, Md.   |  |   |  |   |  |   |   |



100

APR 24 1981

100

100

100

100

100

100

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO. 81 10978  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Walter J. O'Lone  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 15, (4/15/) 81   |  |  | 2b. HOUR<br>11:16aM   |  |
| 3. SEX<br>male  |  | 4. RACE<br>cauc.  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 15, 1922  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>58  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CIA  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Montgomery   |   | 13c. CITY OR TOWN<br>Rockville   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Walter J. O'Lone   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mildred Healy           |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes WW 11 |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>577-24-1803   |  |   | 17. INFORMANT ADDRESS<br>Helen T. O'Lone 1700 Mark Lane Rockville, Md |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>6 years</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u> |  |   |   |   |  |  |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>previous myocardial infarction</u> |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 27</u> , 19 <u>67</u> , to <u>April 15</u> , 19 <u>81</u> , that (I) (we) lost <u>Mar 13</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Wilfred R. Elzermantraut, MD  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>4/15/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wilfred R. Elzermantraut   |  |   |   |   | 22e. ADDRESS<br>11125 Rockville Pike Rockville Md  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Apr. 20, 1981  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rockville Montgomery Md.                          |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Murphy Funeral Home  |  |   |   |   | ADDRESS<br>Arlington, Va. 4510 Wilson Blvd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981   |   | 25b. REGISTRAR'S SIGNATURE   |

Walter J. O'Connell

London

London

London

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |   |  |  |  |  |
|---|--|---|--|--|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>John J. O'NEILL, Jr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 21 1981</b>            |  |   | 2b. HOUR<br><b>11:53P<sub>M</sub></b>  |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 27 1909</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                 |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Appraiser</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>  |  |
| 13a. STATE<br><b>D. C.</b>  |  | 13b. COUNTY<br><b>Washington, DC</b>  |  | 13c. CITY OR TOWN<br><b>Washington, DC</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Joseph O'Neill</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine B. FURGESON</b>   |  | <b>XXXXXXX</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17 INFORMANT<br><b>Mary B. O'Neill</b>   |   | ADDRESS<br><b>See item 13 WIFE</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that I (I) (this hospital) attended the deceased from <b>Apr. 20</b> , 19 <b>81</b> , to <b>Apr. 21</b> , 19 <b>81</b> , that I (we) last saw the deceased alive on <b>Apr. 21</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death)  |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Donald D. Kidd, M.D.</i>   |  |   | DEGREE   |  |   | 22c. DATE SIGNED<br><b>Apr. 22, 1981</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald D. Kidd, M.D.</b>  |  |   | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>    |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>4/24/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Arlington Va.</b> |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>  |  |   | 500. UNIV. BLVD. W<br>ADDRESS<br><b>Silver Spring, Md.</b>             |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. ...</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 10980  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Timothy P. O'Sullivan</b>  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>4/5/1981</b>   |  |   |  | 2b. HOUR <b>1258 PM</b>   |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>cauc</b>                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3/16/13</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>68</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD <b>4/5/81</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISBURSEMENT OFFICER U.S. TREAS.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>  |  |  |  | 13b. COUNTY <b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN <b>WHEATON</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS <b>11937 BLUHILL RD</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>O'SULLIVAN</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>JULIA CROWLEY</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RUPTURED ABDOMINAL ANEURYSM</b><br>4413 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>ABDOMINAL ANEURYSM</b><br>(c) <b>ARTERIOSCLEROSIS</b>  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b><br><b>2-3 d.</b>       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR AM. MONTH DAY YEAR <b>12 P.M. 4 5 1981</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>ACUTE PAIN IN ABDOMEN</b>   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>HOME</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>11937 BLUHILL RD WHEATON MONT. MD</b>   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Francis C. Mayne</b>  |  |  |  | TITLE (SPECIFY) <b>MD. DEPT</b>   |  |  |  | MEDICAL EXAMINER DATE SIGNED <b>4/5/81</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>FRANCIS C. MAYNE</b>   |  |  |  | ADDRESS <b>8200 Wisconsin Ave BETHESDA MD</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  |  | 23b. DATE <b>4/10/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD</b>                               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 5 1981</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>  |  |   |  |

1911  
1912  
1913  
1914  
1915  
1916  
1917  
1918  
1919  
1920  
1921  
1922  
1923  
1924  
1925  
1926  
1927  
1928  
1929  
1930  
1931  
1932  
1933  
1934  
1935  
1936  
1937  
1938  
1939  
1940  
1941  
1942  
1943  
1944  
1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025  
2026  
2027  
2028  
2029  
2030  
2031  
2032  
2033  
2034  
2035  
2036  
2037  
2038  
2039  
2040  
2041  
2042  
2043  
2044  
2045  
2046  
2047  
2048  
2049  
2050  
2051  
2052  
2053  
2054  
2055  
2056  
2057  
2058  
2059  
2060  
2061  
2062  
2063  
2064  
2065  
2066  
2067  
2068  
2069  
2070  
2071  
2072  
2073  
2074  
2075  
2076  
2077  
2078  
2079  
2080  
2081  
2082  
2083  
2084  
2085  
2086  
2087  
2088  
2089  
2090  
2091  
2092  
2093  
2094  
2095  
2096  
2097  
2098  
2099  
2100

Northside Suburban Hospital

1911  
1912  
1913  
1914  
1915  
1916  
1917  
1918  
1919  
1920  
1921  
1922  
1923  
1924  
1925  
1926  
1927  
1928  
1929  
1930  
1931  
1932  
1933  
1934  
1935  
1936  
1937  
1938  
1939  
1940  
1941  
1942  
1943  
1944  
1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025  
2026  
2027  
2028  
2029  
2030  
2031  
2032  
2033  
2034  
2035  
2036  
2037  
2038  
2039  
2040  
2041  
2042  
2043  
2044  
2045  
2046  
2047  
2048  
2049  
2050  
2051  
2052  
2053  
2054  
2055  
2056  
2057  
2058  
2059  
2060  
2061  
2062  
2063  
2064  
2065  
2066  
2067  
2068  
2069  
2070  
2071  
2072  
2073  
2074  
2075  
2076  
2077  
2078  
2079  
2080  
2081  
2082  
2083  
2084  
2085  
2086  
2087  
2088  
2089  
2090  
2091  
2092  
2093  
2094  
2095  
2096  
2097  
2098  
2099  
2100

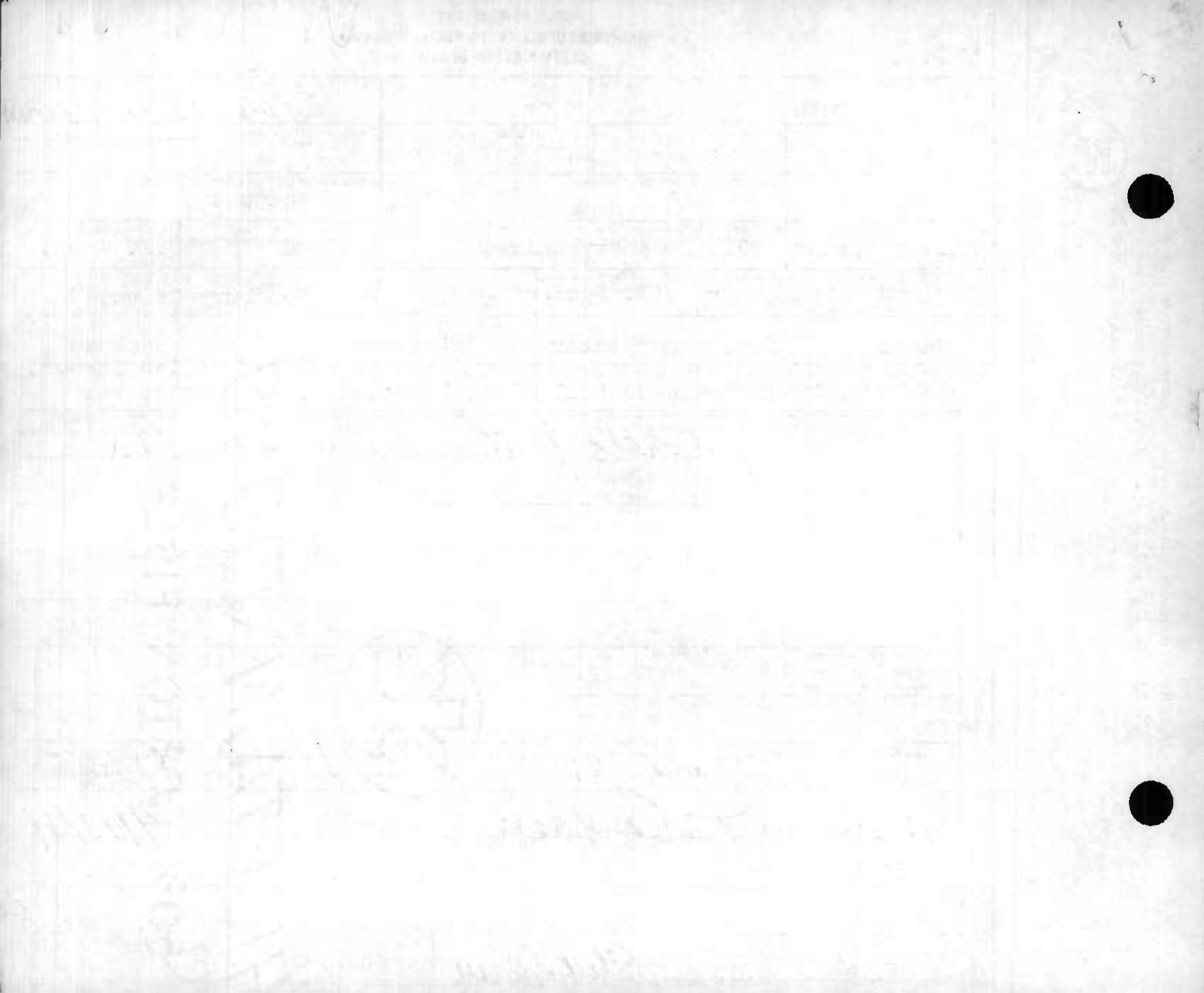
1911  
1912  
1913  
1914  
1915  
1916  
1917  
1918  
1919  
1920  
1921  
1922  
1923  
1924  
1925  
1926  
1927  
1928  
1929  
1930  
1931  
1932  
1933  
1934  
1935  
1936  
1937  
1938  
1939  
1940  
1941  
1942  
1943  
1944  
1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025  
2026  
2027  
2028  
2029  
2030  
2031  
2032  
2033  
2034  
2035  
2036  
2037  
2038  
2039  
2040  
2041  
2042  
2043  
2044  
2045  
2046  
2047  
2048  
2049  
2050  
2051  
2052  
2053  
2054  
2055  
2056  
2057  
2058  
2059  
2060  
2061  
2062  
2063  
2064  
2065  
2066  
2067  
2068  
2069  
2070  
2071  
2072  
2073  
2074  
2075  
2076  
2077  
2078  
2079  
2080  
2081  
2082  
2083  
2084  
2085  
2086  
2087  
2088  
2089  
2090  
2091  
2092  
2093  
2094  
2095  
2096  
2097  
2098  
2099  
2100



DHMH - 16 50M 1/76  
(VR A 15 (4))

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |  | 8 1 1 0 9 8 1 |  |
|---|--|---|--|---|--|---|--|--|--|---------------|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |   |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ruth E. Ott  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 13 1981 9:30 AM  |  |   |  | 2b. HOUR   |  |               |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 25 1923   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>7912 Woodbury Drive, |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.  |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br>Maryland Montgomery   |  |   |  | 13b. CITY OR TOWN<br>Silver Spring  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>7912 Woodbury Drive,  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James E.D. Carpenter  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Barkman  |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>yes  |  |   |  | 16b. SOCIAL SECURITY NO.<br>WW 11 026-22-0827   |  | 17. INFORMATION<br>(Daughter) 2235 Meridian Street,<br>Diana L. Gangl-Falls Church, Va.         |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>4340<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 d  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1962 to April 1981, that (I) (we) last saw the deceased alive on March 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br>William D. Aud, MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>4/13/81  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William D. Aud, MD   |  |   |  | 22e. ADDRESS<br>9006 Colesville Road, S.S. Md.  |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4-16-1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Pr. Georges Md                          |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |               |  |



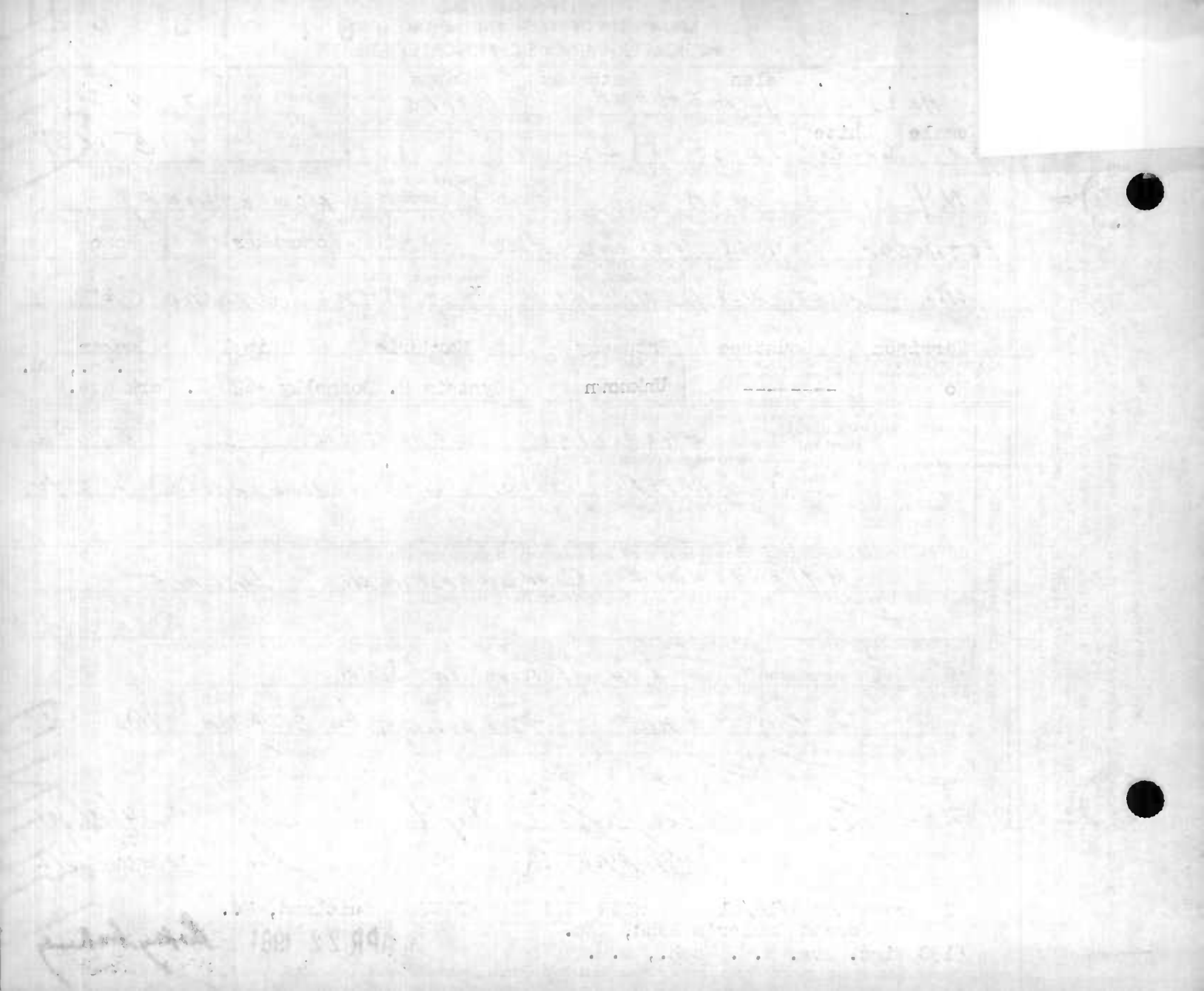
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>Helen</b> MIDDLE <b>Hathaway</b> LAST <b>Papps</b><br><b>HELEN HATHAWAY PAPPS</b>   |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH <input checked="" type="checkbox"/> 4 DAY 4 YEAR 1981 HOUR 8 PM |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>30</b> YEAR <b>1862</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4701 WILLARD AVE</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 13a. STATE<br><b>MD</b>   |   | 13b. COUNTY<br><b>MONTGOMERY</b>  |  |
| 13c. CITY OR TOWN<br><b>BETHESDA</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   | 13e. STREET ADDRESS<br><b>4701 WILLARD AVE</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Harrison</b> MIDDLE <b>Rountree</b> LAST <b>Hathaway</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Marjorie</b> MIDDLE <b>Sibyl</b> LAST <b>Hooker</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |
| 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Cynthia H. Donnelly 4620 N. Park Ave.</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b><br><b>2-3 YRS</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>—</b>   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>—</b>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7 P.M. 4 14 1981</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>FOUND ON SOFA</b>   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |   | 21f. LOCATION<br>CITY OR TOWN <b>BETHESDA</b> COUNTY <b>MONT</b> STATE <b>MD</b>  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Francis C. Mayle</b>   |  | TITLE (SPECIFY)<br><b>MD</b>  |   | MEDICAL EXAMINER<br><b>2800 Wisconsin Ave Bethesda MD</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>FRANCIS C MAYLE MD</b>  |  | ADDRESS<br><b>2800 Wisconsin Ave Bethesda MD</b>  |   | DATE SIGNED<br><b>4/18/81</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>4/16/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CERRAR HILL CREMATORY</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN <b>Suitland, Md.</b> COUNTY <b>—</b> STATE <b>—</b>   |  | 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b><br>NAME <b>5130 Wisc. Ave. N.W. Wash., D.C.</b> ADDRESS                        |   |   |  |
| 25a. DATE RECEIVED BY REGISTRAR<br><b>APR 22 1981</b>   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony [Signature]</b>  |  |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 3 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Honore N. Paquet  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 11 / 81                       |   |  | 2b. HOUR<br>2:25 PM   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 30, 1909  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Vermont   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter   |  | 12b. NAME OF BUSINESS OR INDUSTRY<br>Construction   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Mont. Co.   |  | 13c. CITY OR TOWN<br>Rockville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1201 Simmons Drive  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur - Paquet  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eugenie - Cyr  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None  |  | 17. INFORMANT<br>ADDRESS<br>Gary L. Paquet (Son) Same as # 13.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage Rt<br>5163<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) Acute Feline Illness<br>(c) DUE TO OR AS A CONSEQUENCE OF<br>Interstitial fibrosis lungs |  |  |  |   |  |   |  | SPECIFY INTERVAL BETWEEN CAUSE AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 23 19 81 to Apr 1 19 81 that (I) (we) last saw the deceased alive on Apr 1 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Robert T. Hibbard  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN   |  | 22c. DATE SIGNED<br>Apr 2-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT T. HIBBARD   |  |  |  |   |  | 22e. ADDRESS<br>Rockville Md 20852  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>April/3/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, P.G. Co., Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chambers Funeral Home  |  |  |  |   |  | 25. REGISTERAR'S SIGNATURE<br>ADDRESS<br>Silver Spring, Maryland                                |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1941

1941

1941

1941

1941

1941

1941

1941

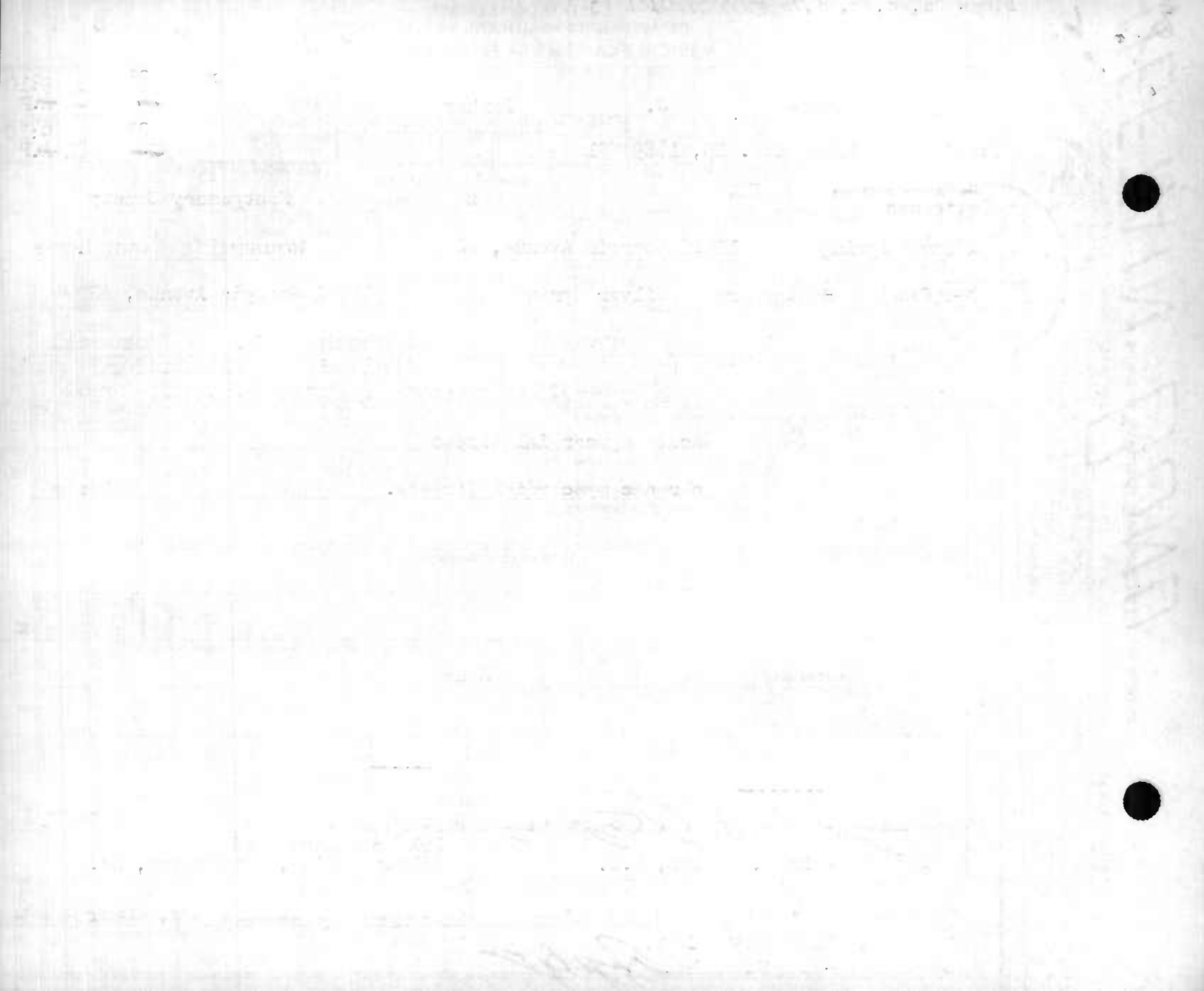
1941



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |   |   |   |  |   |   |  | REG. NO. 10984   |   |  |
|---|--|----------------------|---|---|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Eutie J. Parker</b>   |  |                      |   |   |   |  |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>23</b> YEAR <b>1981</b> |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b> |   | 5. DATE OF BIRTH (MONTH DAY YEAR) <b>Dec. 25, 1889</b>      |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.   |   | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                         |  | 7c. DATE PRONOUNCED DEAD <b>4/24</b> MONTH <b>23</b> YEAR <b>1981</b>                        |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Arkansas Tennessee</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>              |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10002 Georgia Avenue, #2</b> |   |   |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b> |  |
| 13a. STATE <b>Maryland</b>  |  |                      | 13b. COUNTY <b>Montgomery</b>   |   | 13c. CITY OR TOWN <b>Silver Spring</b>                                    |  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>10002 Georgia Avenue, #2</b>                            |  |   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>John A. Cook</b>   |  |                      |   |   |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Elizabeth L. Marshall</b>  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>---</b>   |  |                      | 16b. SOCIAL SECURITY NO. <b>415-48-0259</b>   |   |   | 17. INFORMANT (friend) <b>Frances B. Lusby-S.S. Md. 20902</b>  |   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>chronic myocardial disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>                                |  |                      |   |   |   |  |   |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>  |  |                      |   |   |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>  |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |  |   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>  |   |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |   |   |   |  |   |   |  |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>  |  |                      |   |   |   | TITLE (SPECIFY) <b>Deputy</b>  |   |   | DATE SIGNED <b>4/24/81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>   |  |                      |   |   |   | ADDRESS <b>1915 Seminary Road Silver Spring, Montgomery, Md.</b>   |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      | 23b. DATE <b>4-27-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Brentwood</b> |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pr. Georges Md</b> |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Walner E. Pumphrey, Inc.</b>  |  |                      |   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>4/24/81</b>   |   |   | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| 8434 Ga. Ave., S.S. Md.   |  |                      |   |   |   |  |   |   |  |  |   |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

10985

1. FOR  
STATE  
REGISTRAR

John E. Parker

## CERTIFICATE OF DEATH

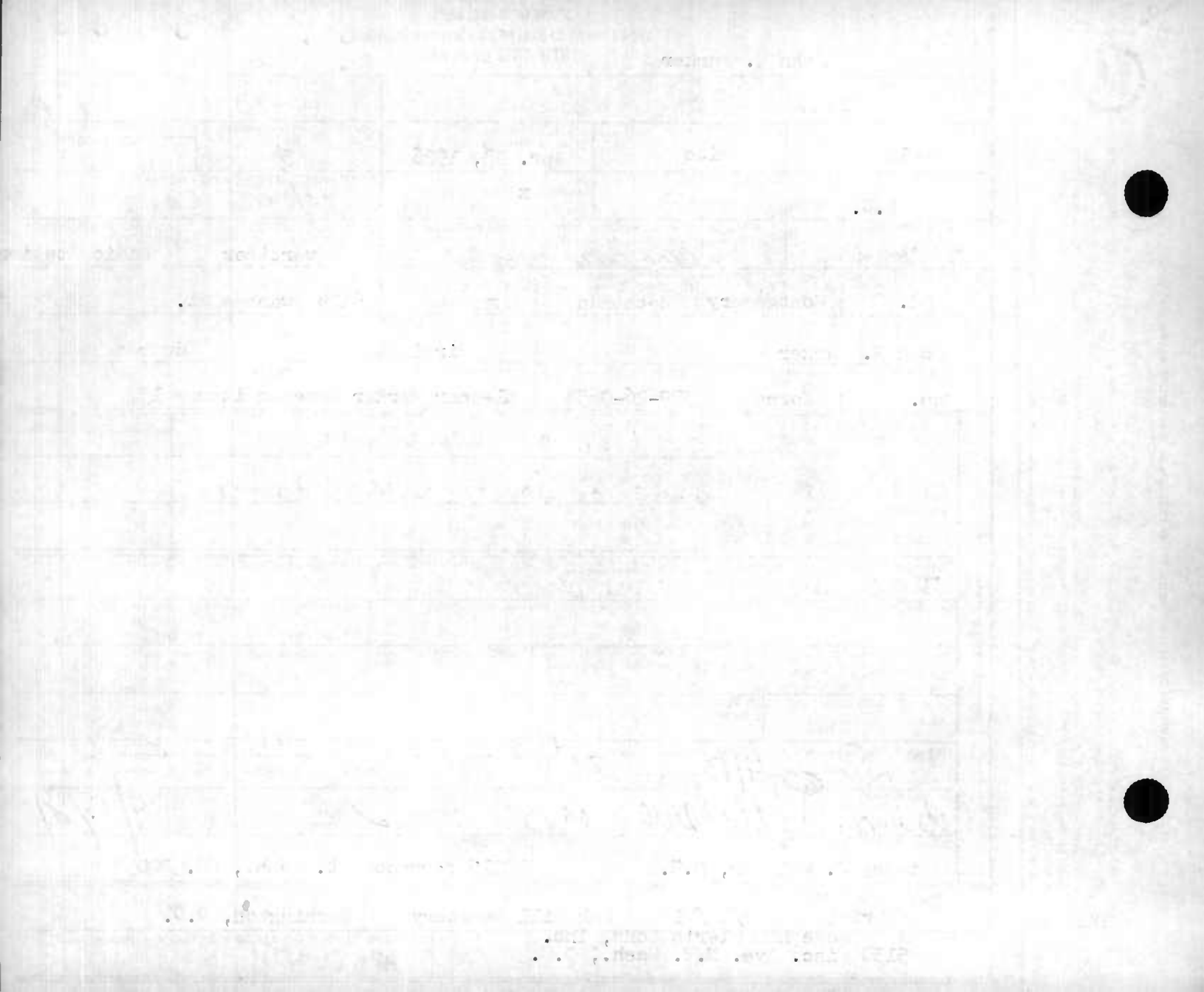
|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John E. PARKER  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-13-81                                 |  | 2b. HOUR<br>11 P.M.  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 23, 1926   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>D.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONT. CO. MD.                                |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Supersan Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Advertiser | 12b. KIND OF BUSINESS OR INDUSTRY<br>Radio Station                                   |  |
| 13a. STATE<br>Md.  |   |   | 13b. COUNTY<br>Montgomery  | 13c. CITY OR TOWN<br>Bethesda  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John E. Parker   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia Edwards              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes.   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Korea  |  | 17. INFORMANT<br>ADDRESS<br>Eleanor Parker Same as item # 13                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiac arrhythmia<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) atherosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |  |  |  |
| Laennec's cirrhosis  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF OTHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/3 19 81 to 4/13 19 81 that (I) (we) last saw the deceased alive on 4/13 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                             |   |   |  |  |  |
| 22b. SIGNATURE<br>Sidney J. Malawer, M.D.  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>4/15/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS<br>10215 Fernwood St. Beth., Md. 20034   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>4/17/81  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Hill Cemetery                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons, Inc.<br>5130 Wisc. Ave. N.W. Wash., D.C.   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1981                                   |  |  |
|  |   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |

417  
70  
35  
150  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELEANOR N. PARKS</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 9, 1981</b>  |  | 2b. HOUR<br><b>9:45 P.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 31, 1902</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Dubuque, Iowa</b>  |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Olney, Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BrookeGrove Foundation</b>   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Secretary</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Civil Service</b>  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13b. STREET ADDRESS<br><b>4640 Gleneagles Dr. 20906</b>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John C. Parks</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Turner</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>480-10-2437</b>  |  | 17. INFORMANT ADDRESS<br><b>532-So. Simmons St. Stockton, Ill. 61085</b><br><b>Jacqueline M. Goodman-niece</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBROVASCULAR ACCIDENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br><b>48 hrs.</b><br><b>1 Month</b> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>DIABETES: CARCINOMA COLON &amp; LIVER METASTASIS</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs.</b>   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (this hospital) attended the deceased from <b>3/16/81</b> to <b>4/9/81</b> , that (I/we) lost saw the deceased alive on <b>4/8</b> and that (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) did not view the body after death. |  | 22b. SIGNATURE <b>D. R. Lewis MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED <b>4/9/81</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. R. LEWIS MD</b>  |  | 22e. ADDRESS<br><b>OLNEY, MARYLAND 20832</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>4-10-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Washington, D.C. 20002</b>  |  | 24. FUNERAL DIRECTOR NAME<br><b>Lee Funeral Home</b>  |  | 25a. DATE REC'D BY REGISTRAR <b>APR 13 1981</b> 25b. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

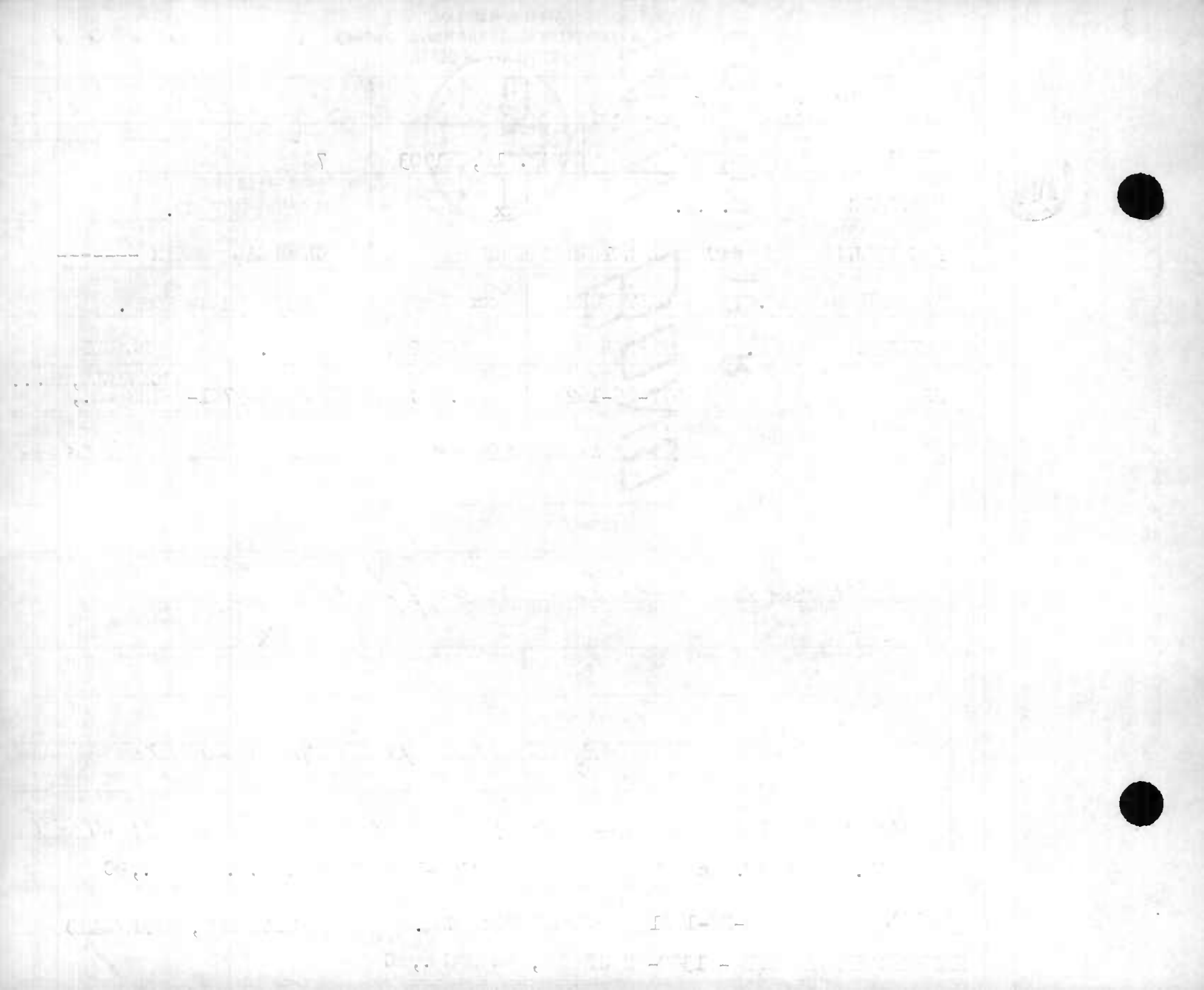
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE BARBARA PAUL</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-21-81</b>   |   | 2b. HOUR<br><b>10<sup>30</sup> A.M.</b>  |   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 18, 1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS. MONTHS DAYS                                      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY CO.</b> MD.                                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NATIONAL LUTHERAN HOME</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERICAL ORK</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----                    |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>BALT.</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br><b>SPRING GROVE HOSP.</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM R. STIPPEL</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ADELINE E. PLAUDI</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577-05-1624</b>  |   | 17. INFORMANT ADDRESS<br><b>REV. RICHARD REICHARD-9701-VEIRS DR.,</b><br><b>ROCKVILLE, MD. ...</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Cerebro-Vasculas Insufficiency</b>   |  |   |   |  |   |
| 19a. DATE OF OPERATION<br>-----  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-----   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 18, 1973</b> to <b>April 21, 1981</b> , that (I) (we) lost<br>saw the deceased alive on <b>April 20, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.     |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Harold F. McCann</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>4-21-81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. HAROLD F. McCANN</b>   |  | 22e. ADDRESS<br><b>3355-16th STREET, N.W. WASH., DC</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-23-1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEM.</b>                                      |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HYSONG FUNERAL HOME</b>   |  | ADDRESS<br><b>- 1300- N STREET, NW WASH., DC</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>APR 23 1981</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  | 27. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |   |

BP



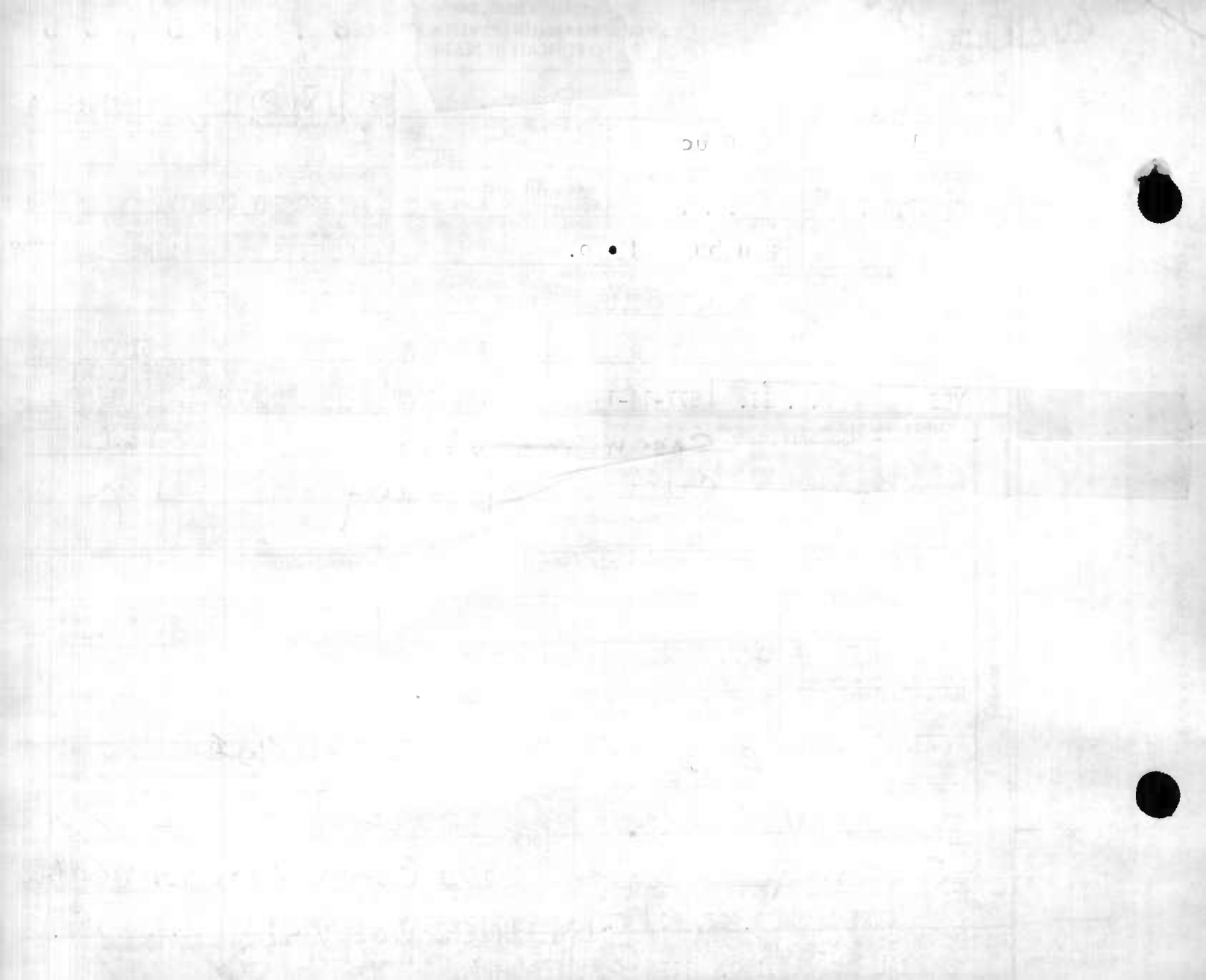


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other trauma event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 8 1 1 0 9 8 8  |  |  |  | REG. NO.  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>Henry Pear  |  |  |  | 2a DATE OF DEATH<br>4/18/81  |  |   |  | 2b HOUR<br>10:25 A.M.   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>CAUCASIAN  |  | 5 DATE OF BIRTH<br>AUGUST 4, 1912  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                 |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CONNECTICUT  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.              |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>EXECUTIVE |  | 12b KIND OF BUSINESS OR INDUSTRY<br>LINEN INDUSTRY  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN ROCKVILLE   |  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br>#7 IRIS COURT                                       |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>JACOB PEAR  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA SIMON  |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II. 577-14-1416   |  | 17 INFORMANT (WIFE)<br>ESTHER PEAR   |  | ADDRESS # 7 IRIS COURT<br>ROCKVILLE, MARYLAND                             |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>1629 Carcinomatosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma of Lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 wk<br>1 yr  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from 4/18/81 19 to 4/18/81 19, that (I) (we) last saw the deceased alive on 4/18/81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22a SIGNATURE<br>Jeremy V Cooke  |  |  |  | DEGREE<br>MD   |  |   |  | 22c DATE SIGNED<br>4/18/81  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeremy V Cooke   |  |  |  | 22e ADDRESS<br>10400 Penn Ave, Kensington  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b DATE<br>APR. 21, 81  |  | 23c NAME OF CEMETERY OR CREMATORY<br>MT. LEBANON CEMETERY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>HYATTSVILLE P.G. MD.         |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME DANZANSKY-GOLDBERG<br>MEMORIAL CHAPELS, INC.   |  |  |  | ADDRESS ROCKVILLE, MD.<br>1170 ROCKVILLE PIKE  |  | 25 DATE REC'D. BY REGISTRAR 26 REGISTRAR'S SIGNATURE<br>APR 22 1981       |  |   |  |



1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |  |   |  |  |
|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Garland W. Pence</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-1-81</b> |  |   | 2b. HOUR<br><b>7:45 AM</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 23, 1901</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ARKANSAS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BUILDING ENGINEER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT.</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>KENSINGTON</b>   |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3913 DECATUR AVENUE</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>IRA R. PENCE</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY A. NEELEY</b>   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>358-10-1732</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>ELIZABETH H. PENCE SAME AS 13 WIFE</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory distress Syndrome</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Viral Bronchitis</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>(c) <b>Chronic Obstructive Lung disease</b> |  |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>2 weeks</b><br><b>years</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pulmonary Tuberculosis, arrested, Diabetes Mellitus, ASHD</b>  |  |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>2</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1970</b> , 19____, to <b>3/31/81</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>3/31/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Jeremy V Cooke</b>  |  |   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br><b>4/1/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeremy V. Cooke</b>  |  |   |  | 22e. ADDRESS<br><b>10400 Conn. Ave Kensington MD</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/4/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT MD.</b>                      |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b> ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 03 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |  |

STANDARD  
PAPER CO. NEW YORK  
MADE IN U.S.A.

COLLOTYPE

NEW YORK



*[Handwritten signature]*

1891 80 89A

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |           |  |  |  |   |  |  |  | REG. NO. 10990   |  |                            |  |
|---|--|-----------|--|--|--|---|--|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>DONALD EDWARD PERRY  |  |           |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH EST. MATED <input type="checkbox"/> 4 18 1981            |  | 2b. HOUR OF DEATH 11:30 AM |  |
| 3. SEX M  |  | 4. RACE N |  | 5. DATE OF BIRTH MONTH DAY YEAR 11 16 33   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.               |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia   |  |           |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.                              |  |                            |  |
| 10. CITY OR TOWN OF DEATH SILVER SPRING   |  |           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1110 FIDDLERS LANE |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Eng.  |  | 12b. KIND OF BUSINESS OR INDUSTRY Electronics                                    |  |                            |  |
| 13a. STATE MD   |  |           |  | 13b. COUNTY MONTGOMERY   |  | 13c. CITY OR TOWN SILVER SPRING                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 11700 OLD COLUMBIA PIKE                                      |  |                            |  |
| 14. FATHER'S NAME FIRST Middle Last Wilbur Theodore Perry   |  |           |  | 15. MOTHER'S MAIDEN NAME FIRST Middle Last Lottie Mae Allen  |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes ?  |  |  |  |                            |  |
| 16a. SOCIAL SECURITY NO. 234-46-9251  |  |           |  | 17. INFORMANT (wife) Evelyn James (same as 13e)  |  |   |  | ADDRESS M. Perry Box 870 Armiger Rd. Huntingdon, Maryland  |  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DIS. 2-3 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |           |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE                               |  |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). PULMONARY INFECTION   |  |           |  |  |  |   |  |  |  |  |  |                            |  |
| 19a. DATE OF OPERATION  |  |           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:18 1981   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) FOUND SITTING IN CAR   |  |  |  |                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET   |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE 1110 FIDDLERS LANE SILVER SPRING MONTGOMERY MD   |  |  |  |                            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |           |  |  |  |   |  |  |  |  |  |                            |  |
| ACTUAL SIGNATURE [Signature]  |  |           |  | TITLE (SPECIFY) Sept   |  |   |  | MEDICAL EXAMINER   |  |  |  |                            |  |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE   |  |           |  | ADDRESS 8200 Wisconsin Ave Bethesda MD   |  |   |  | DATE SIGNED 4/18/81  |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal   |  |           |  | 23b. DATE 4-18-81  |  | 23c. NAME OF CEMETERY OR REMOVAL HOME Lee's Crematory |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC                           |  |                            |  |
| 24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.  |  |           |  |  |  | 25a. DATE REC'D. BY REGISTRAR APR 23 1981             |  |  | 25b. REGISTRAR'S SIGNATURE [Signature] |  |  |                            |  |
| 8434 Ga. Ave., E.S. Md  |  |           |  |  |  |   |  |  |  |  |  |                            |  |

ACUTE  
MYOARDIAL INFARCTION  
HYPERTENSIVE CARDIOMYOPATHY AS  
2/3 3-5

PERMANENT INFECTION

now 4' 11" found sitting in car

TO HOSPITAL-RETAIN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                      |   |                                    | 8 1 10991   |                     |  |  |
|--|----------------------|---|------------------------------------|---|---------------------|--|--|
| 1. FOR STATE REGISTRAR   |                      |   |                                    | REG. NO.  |                     |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>STEPHEN ANTHONY PETRAS   |                      |   | 2a. DATE OF DEATH<br>APRIL 23 1981 |   | 2b. HOUR<br>2:00P M |  |  |
| 3. SEX<br>MALE   | 4. RACE<br>CAUCASIAN | 5. DATE OF BIRTH<br>AUG 23, 1904  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY   |                      | 10. CITY OR TOWN OF DEATH<br>WHEATON  |                                    |   |                     |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>12,714 HOLDRIDGE ROAD   |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SPRINGRIGHT |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF EMPLOYED  |                     |  |  |
| 13a. STATE<br>MARYLAND   |                      | 13b. COUNTY<br>MONTGOMERY   | 13c. CITY OR TOWN<br>WHEATON       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                     | 13e. STREET ADDRESS<br>12,714 HOLDRIDGE ROAD   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JACOB PETRAS   |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY HONKO                     |                                    |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |                      | 16b. SOCIAL SECURITY NO.<br>195-10-0880   |                                    | 17. INFORMANT<br>MARIE M. PETRAS  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF LUNG<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |                                    |   |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                      |   |                                    |   |                     |  |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1 19 80, to APRIL 23 19 81, that (I) (we) lost saw the deceased alive on MARCH 10 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                      |   |                                    |   |                     |  |  |
| 22b. SIGNATURE<br>MARK H. EIG, M.D.  |                      | DEGREE  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                     | 22c. DATE SIGNED<br>APRIL 23, 1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARK H. EIG, M.D.   |                      | 22e. ADDRESS<br>9801 GEORGIA AVENUE   |                                    |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |                      | 23b. DATE<br>4/27/81  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN  |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |                      | 25a. DATE REC'D. BY REGISTRAR<br>APR 23 1981                                    |                                    | 25b. REGISTRAR'S SIGNATURE<br>Ruthie K. Brady   |                     |  |  |



1880

1000

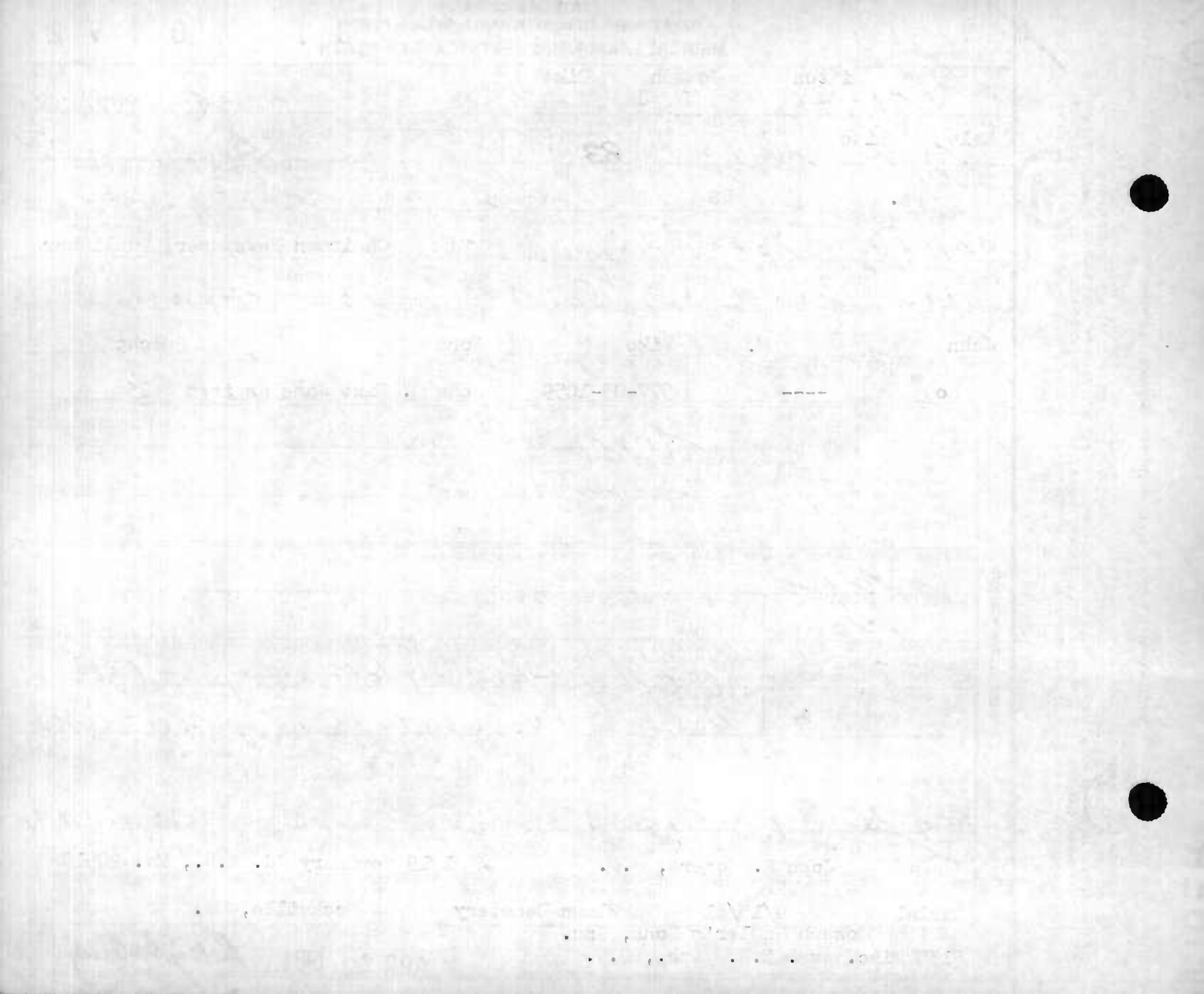
1880



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |  |  | REG. NO. 10992  |  |
|--|--|-------------------------|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Milton Joseph Pike</b>  |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>April 11 1981</b>   |  | 2b. HOUR<br><b>1:00 PM</b>   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 14 1928</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>53 YRS.</b>   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>                              |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sil. Spg.</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10434 Haywood Dr.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chairman Newspaper</b> |  |   |  |
| 13a. STATE<br><b>MD</b>  |  |                         |  | 13b. CITY OR TOWN<br><b>Mont.</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>10434 Haywood Dr.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John M. Pike</b>  |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nora Specht</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>577-03-1059</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>John R. Pike Same as item # 13</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxiation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>8670</b><br>(b) <b>Natural Gas</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                         |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 4 11 1981</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Accidentally left oven pilot light on</b>                               |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Haywood Dr. Sil. Spg. Mont. Md</b>  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |  |                         |  | TITLE (SPECIFY)<br><b>MD</b>   |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED<br><b>April 12 1981</b>                                    |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John S. Rogers, M.D.</b>  |  |                         |  | ADDRESS<br><b>1919 Seminary Rd. S.S., Md. 20910</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>4/15/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Md.</b> |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b><br>NAME ADDRESS<br><b>5130 Wisc. Ave. N.W. Wash., D.C.</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. H. H.</b>                                       |  |   |  |



Items #1a-22a Film G550 6/4/81  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10993  
 REG. NO.

|   |  |  |  |  |
|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Heidi Jane Pilsen</b>   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>4 23 19 81</b> |  | 2b. HOUR<br>M<br><b>1:45 PM</b>  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b>                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 13, 1949</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31 YRS.</b>  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Switzerland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>137 Grafton Street</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Never Worked</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>                                |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Montgomery</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13d. STREET ADDRESS<br><b>137 Grafton Street</b>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis (NMI) Pilsen</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lynn Bernhak</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-52-6882</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Same as Col. Louis Pilsen, Father, item #13</b> |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Barbiturate intoxication</b><br><b>9501</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|  |  |  |  |  |
|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>Est. 4/22/81</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>self ingested</b>  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>137 Grafton St. Chevy Chase Montg. Co. Md.</b> |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |
| ACTUAL SIGNATURE<br><b>H. R. S. Ward</b>   |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  | DATE SIGNED<br><b>4/24/81</b>  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>                        |  |  |

|   |                                |   |   |
|---|--------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>April 1981</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Virginia</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Humphrey Funeral Homes, P.A., Bethesda, Maryland</b> |                                | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 30 1981</b>             | 25b. REGISTRAR'S SIGNATURE<br><b>Henry Hebrud</b>                       |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

5300  
 BP  
 DHMH - 17  
 (VR A15 ME (5))  
 15M 2/80

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

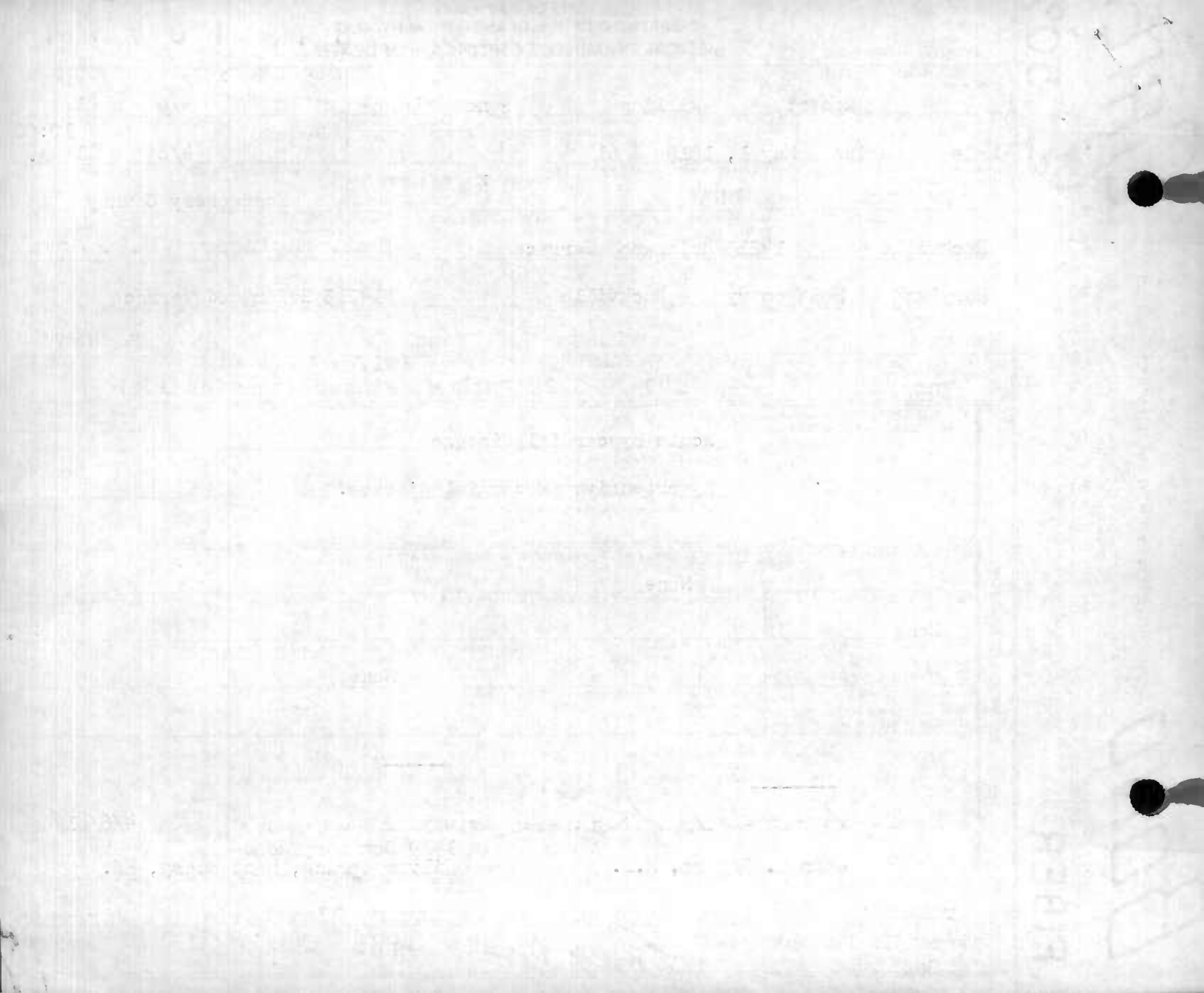
1972

1972

1972

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | REG. NO. 10994   |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |  |  |  |  |
| 2. DECEASED NAME<br>(TYPE OR PRINT) Robert William xxxx Pinnes   |  |   |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 4/6 19 81 |  |
| 3. SEX Male  |  | 4. RACE White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR May 1, 1919                       |  | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.  |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2b. HOUR 10:00   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.                       |  | 2c. DATE PRONOUNCED DEAD 4/6 19 81 A.M.  |  |
| 10. CITY OR TOWN OF DEATH Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14213 Briarwood Terrace |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Engineer  |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.                                     |  |  |  |
| 13a. STATE Maryland  |  | 13b. COUNTY Montgomery  |  | 13c. CITY OR TOWN Rockville  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 14213 Briarwood Terrace                                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Harry Pinnes  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Anna Raskin            |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no  |  |   |  | 16b. SOCIAL SECURITY NO. 107-22-5228                                 |  | 17. INFORMANT (wife) Ruth M. Pinnes-   |  | ADDRESS (same as 13e)  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hypertensive myocardial disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>4029</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION None  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None               |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <i>John S. Rogers</i>   |  |   |  | TITLE (SPECIFY) Deputy MEDICAL EXAMINER                              |  |  |  | DATE SIGNED 4/6/81   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.   |  |   |  | ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.            |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation  |  | 23b. DATE 4-7-1981  |  | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE RECEIVED BY REGISTRAR APR 9 1981                                       |  |  |  |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.  |  |   |  |  |  |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 0 9 9 5   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Elmer Plummer</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Apr 5, 81</b>   |  | 2b. HOUR<br><b>6:15A</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 12, 1915</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Gaithersburg</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8014 Spiceberry Circle</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Montg.</b>  |  | 13c. CITY OR TOWN<br><b>Gaith</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Plummer</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lottie Smith</b>  |  | 16. STREET ADDRESS<br><b>8014 Spiceberry Circle</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-34-1895</b>  |  | 17. INFORMANT<br><b>Miss Mamie V. Plummer (Sister)</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4255</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>alcoholic cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4255</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mmed</b><br><b>yrs</b>   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 70</b> to <b>3/30</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/30</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Willman</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/6/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Willman</b>  |  | 22e. ADDRESS<br><b>15E Deer Park Dr Gaithersburg Md 20878</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-10-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Poplar Grove Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Gaithersburg Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>  |  |   |  | 24b. ADDRESS<br><b>246 N. Washington St, Rockville, Md</b>  |  | 25a. DATE FILED BY REGISTRAR<br><b>APR 5 1981</b>  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |



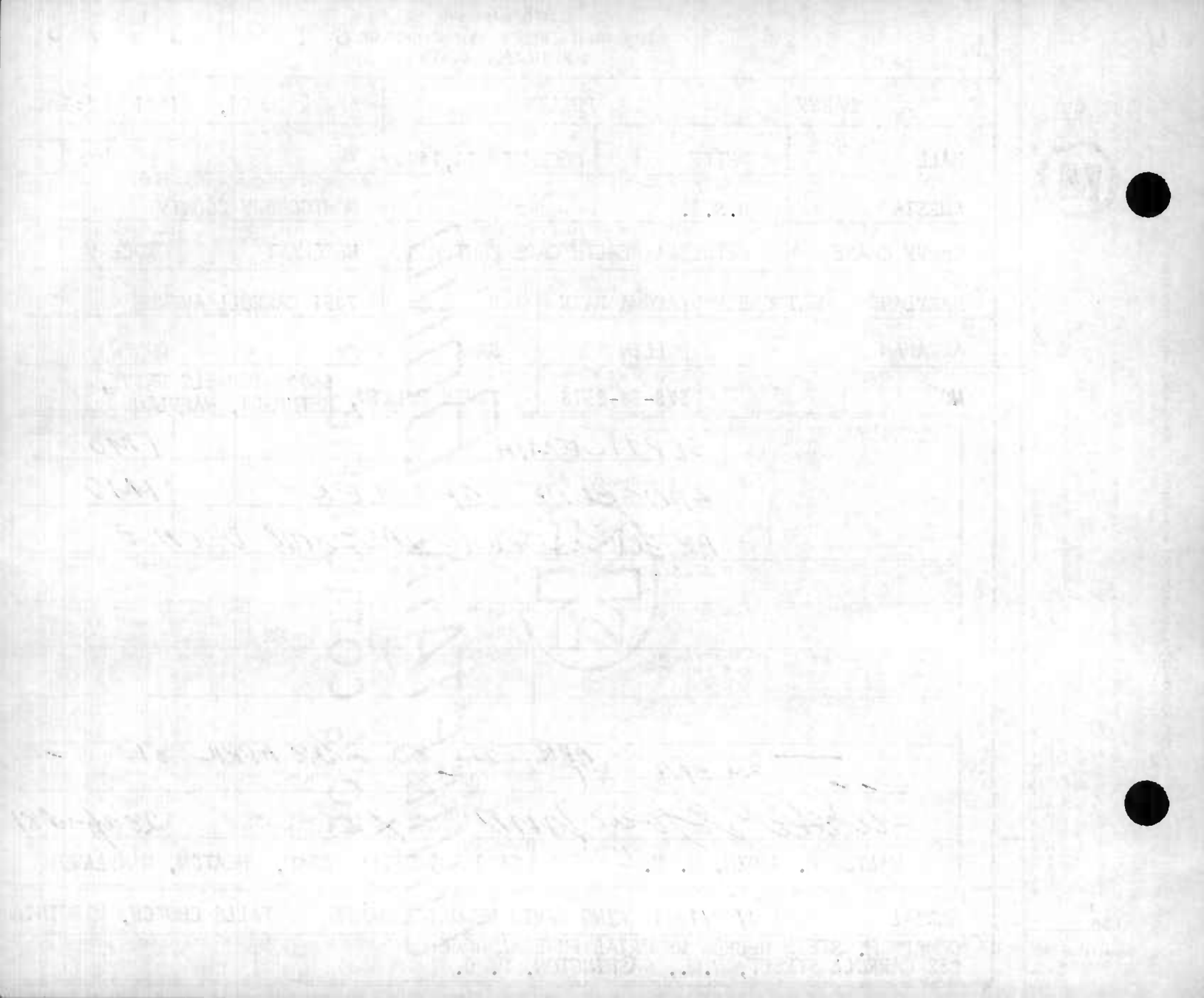
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1701  
152  
135  
97  
90  
35  
152  
1  
2  
9  
1

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |   |  |  |
|--|--|---|--|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 8 1 1 0 9 9 6   |   |   |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY</b> <b>POLLIN</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>28,</b> YEAR <b>1981</b>             |   | 2b. HOUR<br><b>2:30A</b> <small>M</small> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>DECEMBER</b> DAY <b>16,</b> YEAR <b>1890</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>  |   | IF UNDER 1 YEAR<br>MONTHS <small>YRS.</small> DAYS <small>HOURS</small> MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY</b> <small>MD.</small>             |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVY CHASE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF BALTIMORE CITY, GIVE STREET ADDRESS)<br><b>BETHESDA HEALTH CARE CENTER</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MERCHANT</b>             |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GROCERY</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>TAKOMA PARK</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>7051 CARROLL AVENUE</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>ABRAHAM</b> MIDDLE <b>POLLIN</b> LAST <b>POLLIN</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SARA</b> MIDDLE <b>COHEN</b> LAST <b>COHEN</b> |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>578-36-2516</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>IRVIN POLLIN, 6600 MICHAELS DRIVE, BETHESDA, MARYLAND</b>  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b><br><b>4402</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GANGRENE OF LEG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 MO</b><br><b>1 MO</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |
| 22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>APR 30, 1980</b> , to <b>28 APRIL 1981</b> , that (I) <del>last</del> saw the deceased alive on <b>24 APR 1981</b> , and that in (my) <del>an</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>do</del> (did not) view the body after death.   |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Walter E. Goosz MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |   | 22c. DATE SIGNED<br><b>28 April 81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER E. GOOZH, M. D.</b>   |  |   |  | 22e. ADDRESS<br><b>2309 SHOREFIELD ROAD, WHEATON, MARYLAND</b>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/29/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEMORIAL GARDEN</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>FALLS CHURCH, VIRGINIA</b>                                     |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b><br><b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | REG. NO.  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  | 7 1 1 0 9 9 7   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Minnie Poms</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>APRIL 9 1981</i>   |  | 2b. HOUR<br><i>6:00 A.M.</i>  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>December 27, 1905</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>75</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><i>Poland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY COUNTY MD.</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Kensington</i>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>10920 Connecticut Ave., #421</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Abraham Non</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Sylvia Not Known</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>577-44-4177</i>   |  | 17. INFORMANT ADDRESS<br><i>Mrs. Pauline Silverman Alexandria, Virginia 205 Yoakum Pkwy. #512</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory arrest</i><br>4370<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>arteriosclerotic cerebrovascular disease.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>disease.</i> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>immediate</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>February 19 81</i> to <i>9 April 19 81</i> , that (I) (we) last saw the deceased alive on <i>8 April 19 81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) should not view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE DEGREE<br><i>Walter E. Goorh MD</i>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><i>9 April 1981</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>WALTER E. GOORH MD</i>   |  |  |  | 22e. ADDRESS<br><i>2309 SHOREFIELD RD WHEATON MD</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>Burial</i>   |  | 23b. DATE<br><i>4/10/1981</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King David Memorial Garden</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Falls Church, Virginia</i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Donald M. Stein Hebrew Memorial F.H.</i>   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><i>APR 13 1981</i>  |  | 26. REGISTRAR'S SIGNATURE   |  |
| 232 Carroll Street, N. W. Washington, D. C.  |  |  |  |   |  |   |  |

3502



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 1 0 9 9 8   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (LAST, FIRST, MIDDLE)<br><i>Gosh Raymond B</i>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>04 13 81</i>   |  | 2b. HOUR<br><i>11:47 A</i>   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>W</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>6 8 1904</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BETHESDA</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Suburban Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>FARMER</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>MARYLAND</i>  |  |  |  | 13b. COUNTY<br><i>MONTGOMERY</i>  |  | 13c. CITY OR TOWN<br><i>POOLESVILLE</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>ELFIN POOLE</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>LAURA REED</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>218-12-7745</i>  |  | 17. INFORMANT ADDRESS<br><i>MRS. ELLEN POOLE - 21001 WESTERLY RD.</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><i>1629</i><br>IMMEDIATE CAUSE (a) <i>Acute Respiratory Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Pulmonary Atelectasis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Carcinoma of Lung</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Cornary Heart Disease</i> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 17, 1974</i> to <i>April 13, 1981</i> , that (I) (we) lost saw the deceased alive on <i>April 12, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Haris M Kenner MD</i>   |  |  |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>4/13/81</i>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>HARIS M KENNER MD</i>  |  |  |  | 22c. ADDRESS<br><i>10401 Old Georgetown Rd Bethesda MD 20814</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>4/16/81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Monocacy</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Bethesda Montg. Md.</i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>W.C. Kelter</i>  |  |  |  | ADDRESS<br><i>Barnesville Md 20703</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 21 1981</i>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Hester McQuay</i>  |  |  |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 0 9 9 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |                               |   |  |   |  |   |  |   |  |
|---|--|---|-------------------------------|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RACHEL   |  |   | FIRST MIDDLE LAST<br>— PROBER |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL - 18 - 81                           |  |   |  | 2b. HOUR<br>3 P.M.                        |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 15, 1893  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.                 |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>ROCKVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6121 MONTROSE ROAD (HEBREW HOME) |                               |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |  |   |                               | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>ROCKVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6121 MONTROSE ROAD |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS — SOBEL   |  |   |                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RAZA — (UNKNOWN)   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>ADDRESS<br>LOUISE LERDAY 9716 BYEFORDE RD. MD.               |  |   |  | KENSINGTON, MD.                           |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

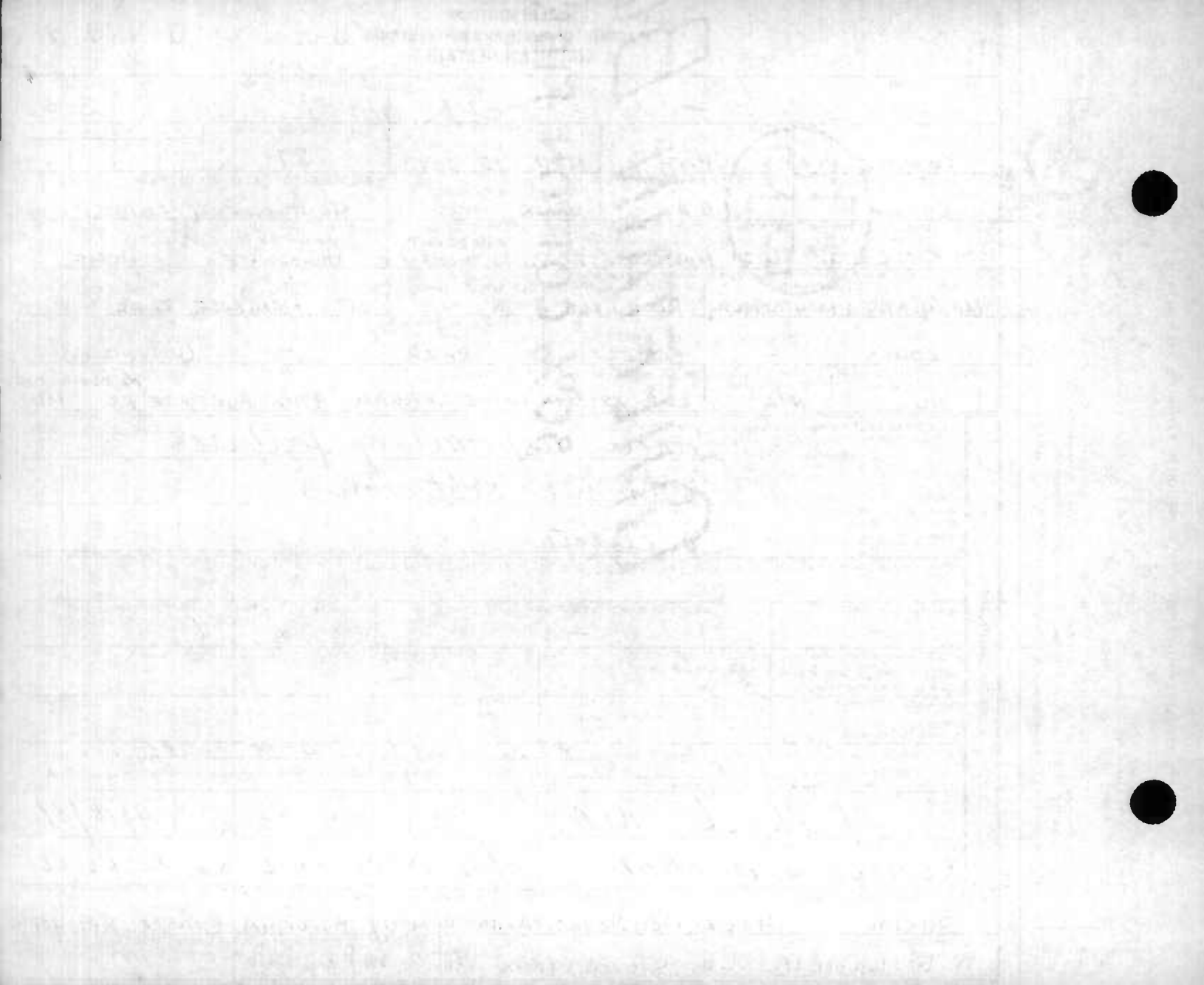
7070 IMMEDIATE CAUSE (a) Cardiorespiratory failure  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF,  
 (b) Chronic septicemia.  
 DUE TO, OR AS A CONSEQUENCE OF,  
 (c) Scurvy.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>3 P.M. 19                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N.H. |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 8-22, 1977, to 4-18, 1981, that (a) (we) last saw the deceased alive on 1-18, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>R. Shah M.D.  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4/18/81.   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KUNJLATA. H. SHAH  |  | 22e. ADDRESS<br>6121 MONTROSE RD. ROCKVILLE                                    |  |  |  |  |  |

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL |  | 23b. DATE<br>APRIL 21, 1981 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT CARMEL CEMETERY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BROOKLYN, KINGS CO. NEW YORK |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. W. CHAMBERS Co.     |  |                             |  | ADDRESS<br>SILVER SPRING, MD.                               |  | 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE<br>APR 23 1981      |  |



CLEARED BY DR. ROGERS, MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 22 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| FOR<br>1- STATE REGISTRAR   |  |  |  |  | 8 1 1 1 0 0 0  |  |  |  |  |
| 1. DECEASED NAME  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |
| (TYPE OR PRINT) <i>Samuel</i>   |  |  |  |  | MONTH DAY YEAR 4 15 81   |  |  |  |  |
| 3 SEX <i>Male</i>   |  |  |  |  | 2b. HOUR 10:35 A.M.  |  |  |  |  |
| 4 RACE <i>White</i>   |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |
|   |  |  |  |  | MONTH DAY YEAR 7 2 09  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna</i>  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS   |  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Takoma Park</i>  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.   |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp</i>   |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>   |  |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <i>Liquor</i>   |  |  |  |  |  |  |  |  |  |
| 13a. STATE <i>Md.</i>   |  |  |  |  | 13b. STREET ADDRESS <i>1305 BALLARD STREET</i>   |  |  |  |  |
| 14. FATHER'S NAME <i>Jacob</i>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME <i>Lena</i>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>  |  |  |  |  | 16b. SOCIAL SECURITY NO. <i>WW-2</i>   |  |  |  |  |
| 17. INFORMANT <i>ERNEST FRIEDMAN</i>  |  |  |  |  | 17. ADDRESS <i>1419 DOROTHY ROAD, N. W. WASHINGTON, D. C.</i>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i>  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial Infarction</i>   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |
| 9a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  |  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/14 19 81, to 4/15 19 81, that (I) (we) lost saw the deceased alive on 4/15/81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE DEGREE   |  |  |  |  |  |  |  |  |  |
| 22c. DATE SIGNED 4/15/81  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEITH M. LINDGREN, M. D.  |  |  |  |  |  |  |  |  |  |
| 22e. ADDRESS 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL   |  |  |  |  |  |  |  |  |  |
| 23b. DATE 4/16/1981   |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY SHOMRE ADAS FUNERAL HOME   |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION 4511 HAMILTON PARKWAY CITY OR TOWN STATE  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL F.H. 232 CARROLL STREET, N. W. WASHINGTON, D. C.   |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |   |
| FIRST MIDDLE LAST<br>Spotswood I. Quinby  |   | MONTH DAY YEAR<br>April 3, 1981   |   | A<br>4:30 M   |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR   |   |
| Male  | Caucasian   | MONTH DAY YEAR<br>June 29, 1926   | 54 YRS.   | MONTHS  | DAYS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |   |
| California  | U.S.A.  |   | Montgomery MD.  |   |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Rockville   | 888 Azalea Drive  |   | Vice President  |   | Retail  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |   |   |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |
| Maryland  | Montgomery  | Rockville   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 888 Azalea Drive  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Spotswood Quinby  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna Isted         |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   | 17. INFORMANT ADDRESS   |   |   |
| No  |   | 575-20-0478   | Ginette N. Quinby, Same as 13                                       |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Small Cell Carcinoma of Thyroid</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>1930</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>6 mo.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?   |   |
|   |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                           |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19____, to <u>4/3/81</u> , 19____, that (I) (we) lost saw the deceased alive on <u>4/2/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   | 22b. SIGNATURE<br><u>Jeremy V Cooke</u><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jeremy V Cooke</u>   |   | 22c. DATE SIGNED<br><u>4/3/81</u><br>22e. ADDRESS<br><u>10400 Connecticut Ave. Kensington, Maryland</u> |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>  |   | 23b. DATE<br><u>April 4, 1981</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Metropolitan Crematory Alexandria, Virginia</u>                |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>ROBERT A. PUMPHREY FUNERAL HOMES,</u><br><u>P. A., Rockville, Maryland</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 08 1981</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |

MEDICAL CERTIFICATION

BP



John F. Kennedy

808 Webster Drive

Rocky Hill, Connecticut

March 20, 1961

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

I am writing to you today

to express my appreciation

for the information you

have provided me with

regarding the activities

of the various groups

operating in the area

of the New York City

area. I am sure that

your report will be of

great value to the

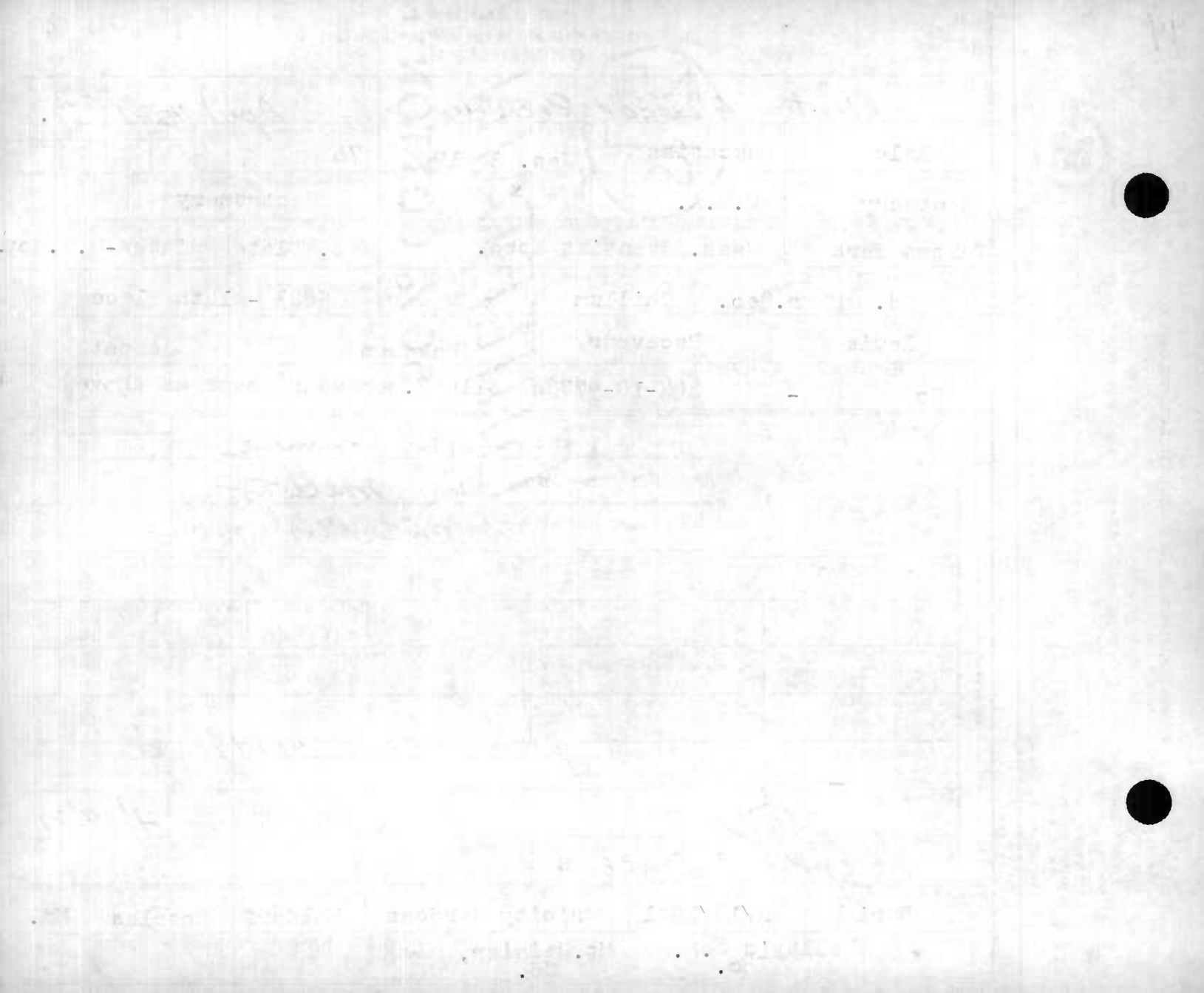


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 1 1 1 0 0 2  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |
| Albert Alexander Receveur  |  |  |  |  |  |  |  |  |  | April 14/1981  |  |
| 3. SEX Male  |  |  |  |  |  |  |  |  |  | 7b. HOUR 3:13 P.M.   |  |
| 4. RACE Caucasian  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |
| Jan. 3 1905  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH Takoma Park  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.                             |  |
| 12a. USUAL OCCUPATION Ret. Plate Printer   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR TYPE OF WORK FOR MOST OF WORKING YEARS U.S.Gov.   |  |
| 13a. STATE Md.   |  |  |  |  |  |  |  |  |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13c. CITY OR TOWN Pr. Geo. Chillum   |  |  |  |  |  |  |  |  |  | 13d. STREET ADDRESS 5803 - 14th Place  |  |
| 14. FATHER'S NAME Lewis  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME (Unknown) Bennet  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 404-10-9778A  |  |
| 17. INFORMANT Ella R. Receveur (same as above)   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal Carcinoma  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) chronic renal failure   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/29/ 19 81, to 4/14/ 19 81, that (I) (we) lost saw the deceased alive on 4/13/ 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE 278 DEGREE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 4/14/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE 4/18/1981  |  |
| 23c. NAME OF CEMETERY OR CREMATORY Trinity Gardens   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Md.  |  |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.   |  |  |  |  |  |  |  |  |  | 24b. ADDRESS Mt. Rainier, Md.  |  |
| 24c. DATE RECD. BY REGISTRAR APR 21 1981   |  |  |  |  |  |  |  |  |  | 24d. REGISTRAR'S SIGNATURE   |  |



|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RAYMOND R. REDMOND</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>4</b> YEAR <b>26</b> DAY <b>81</b>  |  | 2b. HOUR<br><b>10-45A</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>24</b> YEAR <b>06</b>   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. CITY OR TOWN OF DEATH<br><b>Kensington</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(TYPE IN FULL NAME AND STREET ADDRESS)<br><b>Kensington Gardens Nursing Home</b> |  | 12a. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Ijamsville</b>  |  | 14. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 15. STREET ADDRESS<br><b>Route 1 Box 130</b>  |  |
| 16. FATHER'S NAME<br>FIRST <b>Pete</b> MIDDLE <b>Redmond</b>   |  | 17. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>  |  | 18. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> 19. IF YES, GIVE WAR OR DATES <b>--</b>                                       |  |
| 20. SOCIAL SECURITY NO.<br><b>214-18-8705</b>  |  | 21. INFORMANT<br><b>D.L. Redmond</b>  |  | 22. ADDRESS<br><b>7215 Drum St. Capital Hts. Md.</b>  |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic - Respiratory Arrest</b><br>1639<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Metastatic Carcinoma of the Lung</b><br>(c) <b>Mon the</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Month</b> |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |
| 24. DATE OF OPERATION  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |   |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 33. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 34. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 35. I certify that (I) (this hospital) attended the deceased from <b>April 10 1981</b> to <b>April 26 1981</b> , that (I) (we) last saw the deceased alive on <b>April 23 1981</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |  |   |  |
| 36. SIGNATURE<br><b>Bartholomew H. Venable, M.D.</b>   |  | 37. DEGREE<br><b>M.D.</b>   |  | 38. DATE SIGNED<br><b>4-28-81</b>   |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bartholomew H. Venable, M.D.</b>  |  | 40. ADDRESS<br><b>3720 Fairview Ave. Ken. Md 20755</b>  |  |   |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 42. DATE<br><b>4/29/81</b>  |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>Washington Nat'l Cemetery Suitland, Maryland</b>  |  |
| 44. FUNERAL DIRECTOR<br>NAME <b>Tyson Wheeler Funeral Home, Inc.</b>   |  | 45. DATE REC'D. BY REGISTRAR<br><b>APR 1 1981</b>   |  | 46. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 47. ADDRESS<br><b>1331 Rockville Pike Rockville, Md.</b>   |  |   |  |   |  |



|            |                                 |             |    |    |  |
|------------|---------------------------------|-------------|----|----|--|
| Male       | White                           | 8           | 24 | 06 | 74                                       |
| Maryland   | USA                             | x           |    |    | Montgomery                               |
| Kensington | Kensington Gardens Nursing Home |             |    |    | made crosses                             |
| Imber      |                                 |             |    |    |  |
| Maryland   | Frederick                       | Ijansville  | x  |    | Route 1 Box 150                          |
| Page       | Redmond                         |             |    |    | Unknown                                  |
| no         | ---                             | 214-18-8705 |    |    | D.I. Redmond 2515 Drive St. Capital Hill |
|            |                                 |             |    |    | Nb.                                      |

1931 Rockville Pike Rockville, Md.  
Tyson Wheeler Funeral Home, Inc.  
Burial 4/29/81 Washington Nat'l Cemetery Suitland, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |  | 8 1 1 0 0 4  |  |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |   |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Grace C. Richards  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 8 1981                                  |  | 2b. HOUR<br>1:30A M  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 9 1889   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bethesda Retirement & Nursing Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |
| 13a. STATE<br>D.C.   |   | 13b. CITY OR TOWN<br>Washington   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>3847 Fessenden St., N.W.                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William C. Chauncey  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cassie Ludwig  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>577-48-6501   |  | 17. INFORMANT<br>ADDRESS<br>Catherine Cogrove, Dtr., Same as item 13.          |  |
| 18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Massive Cerebral Vascular Accident<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerotic Vascular Disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 m |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (the hospital) attended the deceased from Dec 16, 1944, to April 2, 1981, that (I) (we) last saw the deceased alive on April 6, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br>William F. Lockett, M.D.   |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>4/8/1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William F. Lockett, M.D.  |   | 22e. ADDRESS<br>5000 Reno Road., N.W. Washington, D.C.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>4/10/1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Maryland   |   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons Inc<br>5130 Wisc. Ave., N.W. Wash., D.C.  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 15 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                      |  |

2005: 101

Abstract

55

52

238 120 121 122

5

100-100-100

X

• • •

Figure 1

• • •

• •

• 15

7. 3111 62

•

Figure 1

112784

4

• • • • •

• • • • •



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |                                     |  |
|--|--|---|--|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ralph Smith RIGGS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 28 1981</b>        |  | 2b. HOUR<br><b>2:30A</b>            |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 20 1895</b>                            |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Texas</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                    |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |                                     |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK AND CITY OF WORKING LIFE)<br><b>Officer (Ret)</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Navy</b>              |  |                                     |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Montgomery</b>                                   |  | 13c. CITY OR TOWN<br><b>Potomac</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Newton Riggs</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>Minnie C. Little</b> |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI&amp;WWII</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>D. C. Arthur G. Lambert 1629-K St., N.W. Wash.</b>    |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory distress</b><br><b>1850</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Prostatic carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |  |                                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                     |  |
| 22a. I certify that (I/this hospital) attended the deceased from <b>Feb. 19</b> 19 <b>81</b> to <b>Apr. 28</b> 19 <b>91</b> , that (I/we) lost<br>saw the deceased alive on <b>Apr. 28</b> 19 <b>91</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) did (did not) view the body after death.                                  |  |   |  |  |                                     |  |
| 22b. SIGNATURE<br><b>Mark D. Browning, M.D.</b>  |  |   |  | 22c. DATE SIGNED<br><b>Apr. 28, 1981</b>   |                                     |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark D. Browning, M. D.</b>  |  |   |  | 22d. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>                  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/4/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>                      |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Jos. Gawler Sons</b>  |  | ADDRESS<br><b>Washington, D. C.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Arlington Va.</b>         |                                     |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 1 - 1981</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard K. Brady</b>                                |                                     |  |

MEDICAL CERTIFICATION



1351

XX

U.S. Navy

(10-1-1941)

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

1351/4/2

1351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  | 8 1 1 1 0 0 6                                |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH                            |  |  |   |  |  |
| FIRST MIDDLE LAST  |  |  |   |  | MONTH DAY YEAR                               |  |  |   |  |  |
| Reamer Jesse RIKER   |  |  |   |  | April 23 1981                                |  |  |   |  |  |
| 3 SEX  |  | 4 RACE   |   | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7b. HOUR  |  |  |
| Male   |  | Caucasian  |   | MONTH DAY YEAR<br>July 9 1934  |  | 46   |  | 5:17P M   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |
| New York   |  | USA  |   |  |  | Montgomery MD  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Bethesda   |  | National Naval Medical Center  |   |  |  | U.S. Air Force/Capitol Police  |  |   |  |  |
| 13a. STATE   |  |  |   |  | 13b. COUNTY                                  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland   |  |  |   |  | Pr. George                                   |  | District Heights   |   | 6530 Halleck Street  |  |
| 14. FATHER'S NAME  |  |  |   |  | 15. MOTHER'S MAIDEN NAME                     |  |  |   |  |  |
| FIRST MIDDLE LAST  |  |  |   |  | FIRST MIDDLE LAST                            |  |  |   |  |  |
| John Reamer Riker  |  |  |   |  | Mary Beatrice Halliday                       |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   |  | 16b. SOCIAL SECURITY NO.                     |  | 17 INFORMANT ADDRESS   |   |  |  |
| Yes  |  |  |   |  | 1953-73                                      |  | Margaret O. Riker See item 13  |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).   |  |  |   |  |  |  |  |   |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior inferior myocardial infarction   |  |  |   |  |  |  |  |   |  |  |
| 4100   |  |  |   |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |   |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|  |  |  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
|  |  |  | P.M. 19   |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |
|  |  |  |   |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr. 13 1981 to Apr. 23 1981, that (I) (we) lost the deceased alive on Apr. 23 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE   |  |  |   |  | DEGREE                                       |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| Robert Chin, Jr. M.D.  |  |  |   |  | MD   |  |  |   | Apr. 24 1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  | 22e. ADDRESS                                 |  |  |   |  |  |
| Robert Chin, Jr. M.D.  |  |  |   |  | National Naval Medical Center, Bethesda, Md. |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |
| Burial   |  | 27Apr 1981   |   | Epiphany Episcopal Church Cemetery   |  | Forestville Pr. George Md.   |  |   |  |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR                |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |
| Robert E. Wilhelm Funeral Home Suitland, Md.   |  |  |   |  | APR 29 1981                                  |  | Robert E. Wilhelm  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |  |  | 8 1 1 1 0 0 7 |  |
|--|--|--|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Edward N. Riley</i>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>April 4, 1981</i>                            |  | 2b. HOUR<br><i>3:30 PM</i>   |  |               |  |
| 3. SEX<br><i>MALE</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>9/15/83</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>97</i>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington D.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                       |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rockville, Md</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Collingswood Nursing Home</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Electrician</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Govt.</i>  |  |               |  |
| 13a. STATE<br><i>DC</i>  |  | 13b. COUNTY<br><i>Washington</i>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><i>4401 Brandywine St. N.W.</i>                              |  |  |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Eli Riley</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Agnes Brooke</i>   |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>W.W. I 577-58-9278</i>  |  | 17. INFORMANT<br><i>John Derrick</i>  |  | ADDRESS<br><i>4401 Brandywine St. N.W. Washington, D.C. 20016</i>                   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Heart Disease</i><br>Chronic<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days</i>  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/3/79</i> 19 <i>81</i> , to <i>4/4/81</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>4/19/81</i> 19 <i>81</i> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><i>R. Tilley M.D.</i>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br><i>4/4/81</i>   |  |  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>RUSSELL TILLEY</i>   |  |  |  | 22e. ADDRESS<br><i>4701 Mass Ave N.W.</i>   |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>8 Apr 1981</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Rock Creek Cemetery</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Washington DC</i>                     |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Hines/Rinaldi Funeral Home</i><br>ADDRESS <i>11800 New Hampshire Ave, Silver Spring, Md</i>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 8 1981</i>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  |  | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARVEY H. ROBERTS</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-16-81</b> 2b HOUR<br><b>8:45P M</b>         |  |  |  |   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 17 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63 65</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>                         |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired carpenter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NIH</b>                  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry B. Roberts</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Mae Baxter</b>            |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>  |  | 17. INFORMANT<br><b>Viola V. Dunagan</b>   |  | ADDRESS<br><b>Rt. 211 Amosville, Va.</b>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio-respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>metastatic carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b><br><b>5 yrs</b> |  |   |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Post CUA</b>   |  |   |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>2/9</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Post CUA</b>   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1969</b> , to <b>16 Mar 1981</b> , that (I) (we) last saw the deceased alive on <b>16 APR 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>John M. Wynan</b>   |  |   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>4/17/81</b>                               |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN M WYNAN</b>   |  |   |  | 22e. ADDRESS<br><b>7501 North Ave Beltsville, MD 2084</b>  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/21/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                     |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b>  |  |   |  | 25. REGISTRAR'S SIGNATURE<br><b>APR 22 1981</b>  |  |  |  |  |   |  |
| 1331 Rockville Pike Rockville, Maryland  |  |   |  |  |  |  |  |  |   |  |

52

0-100

2015-2016

May 1994

A62

2

Received 10/2/2007

Будет ли?

Montgomery, E. J.

5079 Broadway, N.Y.C.

VT26

•

Родина

012031M

can

Text

On

—

0442 20 815

Второй вариант. Исходный вариант

6874

Id. 1534.

07-02-2008

Belting, Maryland

Tycoo Electric, General Home, Inc.

Handwritten: 01/15/2001 01:10:00 PM



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8111009   |  |   |  |                            |  |
|---|--|--|--|---|--|--|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Alice J. Robertson</i>   |  |  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>4/29/81</i>   |  |   |  | 2b. HOUR<br><i>4:25 PM</i> |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4 17 12</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><i>69</i>   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><i></i>  |  | 7. IF UNDER 24 HRS. HOURS MIN.<br><i></i>   |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.  |  |  |  |   |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired C&amp;P Telephone Co</i> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i></i> |   |  |                            |  |
| 13a. STATE<br><i>Md.</i>  |  |  |  | 13b. COUNTY<br><i>Montgomery</i>  |  | 13c. CITY OR TOWN<br><i>Rockville</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>4913 Baffin Bay Lane</i>  |  |                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>George H. Schneider</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Ruth Fox</i>   |  |  |  |  |  |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>---</i>  |  | 17. INFORMANT<br><i>Jean A. Ehatt</i>  |  | ADDRESS<br><i>4913 Baffin Bay Lane Rockville, Md.</i>  |  |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Oat Cell Carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>  |  |  |  |   |  |  |  |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION<br><i>4/16</i>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Supr. Lung mass</i>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |  |  |   |  |                            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/23</i> , 19 <i>81</i> , to <i>4/29</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>4/25</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.            |  |  |  |   |  |  |  |  |  |   |  |                            |  |
| 22b. SIGNATURE<br><i>Jay Weiner MD</i>  |  |  |  | DEGREE<br><i>MD</i>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>4/29/81</i>  |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Jay Weiner</i>  |  |  |  | 22e. ADDRESS<br><i>50 W. Edmonston Dr., Rockville, Md.</i>  |  |  |  |  |  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |  |  | 23b. DATE<br><i>May 2/ 1981</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn Cemetery</i>                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Rockville, Maryland</i>  |  |   |  |                            |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Warner E. Pumphrey, Inc.</i>  |  |  |  | 24b. ADDRESS<br><i>8434 Ga. Ave. Sil. Spr., Md.</i>   |  |  |  | 25a. DATE REG. D. BY REGISTRAR<br><i>MAY 6 1981</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |                            |  |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR   |  |  |  |
| John H ROSENBERGER  |  |  |  | April 5-1981 11 <sup>09</sup> A.M.   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| MALE  |  | WHITE  |  | FEB. 25, 1889  |  | 92 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| MARYLAND  |  | U.S.A.   |  |  |  | MONTGOMERY CO. MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| ROCKVILLE   |  | NATIONAL LUTHERAN HOME   |  | MACHINIST  |  | INDUSTRIAL   |  |
| 13a. USUAL RESIDENCE (IF NOT IN HOME OF OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE  |  |  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS  |  |
| MARYLAND UNKNOWN  |  |  |  | LINEBORO   |  | 21605 - GUNPOWDER ROAD   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| JOHN W. ROSENBERGER   |  |  |  | REBECCA EBERLINE   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| NO  |  | 218-26-1371-A  |  | EXECUTIVE DIRECTOR ROCKVILLE, MD.<br>REV. DR. RICHARD REICHARD-NLH-9701-VEIRS DR.,   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u> |
| 4292 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>(b) <u>arteriosclerotic Cardio-Vascular Disease 5 yrs.</u><br>(c) <u>Cerebro-Vascular Insufficiency</u>  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebro-Vascular Insufficiency</u>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 27, 1978</u> , to <u>April 5, 1981</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>Harold F. McCann</u>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|   |  |  |  |  |  | 4-5-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| HAROLD F. McCANN  |  |  |  | 3355 - 16th STREET, N.W. WASH., DC   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| BURIAL  |  | APR. 8, 1981   |  | LOUDON PARK CEMETERY   |  | BALTIMORE, MARYLAND  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25. DATE REC'D. BY REGISTRAR   |  |  |  |
| HYSONG FUNERAL HOME - 1300-N ST., NW WASH., DC  |  |  |  | APR 14 1981  |  |  |  |
|   |  |  |  | 26. REGISTRAR'S SIGNATURE  |  |  |  |

BP

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial system and for providing a clear audit trail. The document also notes that this practice is essential for identifying and preventing fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the process, from the initial entry of data into the system to the final review and approval. The document also includes a list of the required documents and information for each step.

3. The third part of the document discusses the role of the accounting department in the overall financial management of the organization. It highlights the department's responsibility for ensuring that all transactions are recorded accurately and in a timely manner. The document also notes that the accounting department is responsible for providing regular reports to management on the organization's financial performance.

4. The fourth part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial system and for providing a clear audit trail. The document also notes that this practice is essential for identifying and preventing fraud.

5. The fifth part of the document outlines the specific procedures for recording transactions. It details the steps involved in the process, from the initial entry of data into the system to the final review and approval. The document also includes a list of the required documents and information for each step.

6. The sixth part of the document discusses the role of the accounting department in the overall financial management of the organization. It highlights the department's responsibility for ensuring that all transactions are recorded accurately and in a timely manner. The document also notes that the accounting department is responsible for providing regular reports to management on the organization's financial performance.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                         |  |   | 8 1 1 1 0 1 1   |  |
|---|-------------------------|--|---|---|--|
| 1 - FOR STATE REGISTRAR   |                         |  |   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rosemary Bachman Roth</b>   |                         |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 20 '81</b>                           |   | 2b. HOUR<br><b>10:00 P.M.</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 23, 1931</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |                         |  | 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>                                   |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8104 Larry Place</b>   |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |                         |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Chevy Chase</b>                                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Millard E. Bachman</b>  |                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ruth C. Bachman</b>              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>579-40-9502</b>                                    |   | 17. INFORMANT ADDRESS<br><b>Richard L. Roth 8104 Larry Pl., Ch. Ch., Md.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1749 Carcinoma of the Breast with metastases</b><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                         |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                         |  |   |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                         | 22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19 <b>April 20</b> , to <b>81</b> , that (I) (we) last saw the deceased alive on <b>April 5</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |  |
| 22b. SIGNATURE<br><b>Raymond Scalettar</b>  |                         | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>April 20 '81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raymond Scalettar MD</b>  |                         | 22e. ADDRESS<br><b>730 24th Street N. W. Washington, D. C.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |                         | 23b. DATE<br><b>Apr. 21, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland-Prince Georges Md.</b>   |                         | 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N. W. Washington, D. C.</b>  |   |   |  |
| 25a. DATE RECD. BY REGISTRAR<br><b>APR 24 1981</b>  |                         | 25b. REGISTRAR'S SIGNATURE   |   |   |  |

June 2, 1931

X

to the

U. S. A.

Illinois

Chicago

for

the

the

the

the

the

the

the

the

the

the

the

the

the

the

the

13

11

750 5th Street, Washington, D. C.

Hyman, Joseph

Joseph Hyman's sons Inc.  
Washington, D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH-17  
(VR A15 ME (5))  
15M2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |   |  | REG. NO. 11012   |  |
|--|--|----------------------|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kathleen Suzanne Rowley</b>   |  |                      |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>4 26 19 81</b> |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Dec 27, 1958</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>22 YRS.</b>                    |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2b. HOUR <b>M</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD <b>4 26 19 81</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>  |  | 2d. HOUR <b>11:55 P.M.</b>   |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Potomac</b>                                     |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>10620 River Road</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Eugene T. Harris</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Dolores Mummert</b> |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>218-82-6846</b>   |  | 17. INFORMANT ADDRESS <b>James Michael Rowley Same as 13 Husband</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                      |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                      |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE OF DEATH<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>10:05 P.M. 4 26 19 81</b>  |  |                      |  | 21b. TIME OF INJURY<br>HOUR <del>XXX</del> MONTH DAY YEAR <b>4 26 19 81</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>driver in auto/auto collision</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>13300 River Rd., Potomac, Montgomery Co., Md.</b>  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>  |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b>   |  |  |  | DATE SIGNED <b>4-27-81</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>4/29/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Lutheran Church</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Smithsburg Wash. Md.</b>                       |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 4 1981</b>                      |  | 25b. REGISTRAR'S SIGNATURE <b>Patricia Kelly</b>  |  |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |                      |  |   |  |  |  |   |  |  |  |

6002





Handwritten text at the bottom left corner, possibly a signature or initials.

Page

788

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 1 0 1 3  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR HOUR  |  |  |  |
| Pearl M. Rupp   |  |  |  | 4 6 81 2:20 PM   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female  |  | White  |  | MONTH DAY YEAR   |  | 7. IF UNDER 1 YEAR   |  |
|   |  |  |  | Jan. 24, 1894  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Wash. D.C.  |  | U.S.A.   |  |  |  | Montgomery County MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda  |  | Suburban Hospital  |  | Photo-Retoucher  |  | U.S. Gov't.  |  |
| 13a. STATE  |  |  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS  |  |
| Maryland  |  |  |  | College Park   |  | 9234 St. Andrew Place  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST  |  |  |  |
| Charles W. Spates   |  |  |  | Mary V. Wood   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| No  |  |  |  | 579-03-0272  |  | Address Same As No# 13c.                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Terminal aspirated pneumonia  |  |  |  |  |  |  |  |
| 0381 DUE TO, OR AS A CONSEQUENCE OF (b) Staphylococcal septicemia   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) —  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) —   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to 4/6/81, 19, that (I) (we) lost saw the deceased alive on 4/6/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|   |  |  |  | MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>            |  | 4/6/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| 050 TH LEKAGUR MD   |  |  |  | 7425 arlington Rd, Bethesda Md   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 4-8-81   |  | Ft. Lincoln Cemetery   |  | Brentwood P.G. Maryland  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md.  |  |  |  | APR 9 1981   |  |  |  |

U. S. Office of Education, Washington, D. C.  
Division of Secondary Education  
Bureau of Secondary Curriculum Development  
Washington, D. C.

Report of the Committee on the  
Secondary Curriculum  
1918-1919

Published by the U. S. Government Printing Office

Washington, D. C., 1918

Price, 10 cents

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHM 16-50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |   | 8111014  |  |
|---|--|--|--|---|--|--|--|---|---|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MICHAEL ALLEN RUSH</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>APRIL 17, 1981</b>  |  |   | 2b. HOUR<br><b>4:00 P.M.</b>                          |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUC</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 4 1947</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>34</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>   |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAT'L NAVAL MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>EDITOR</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NEWSPAPER</b> |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>OHIO</b> 13b. COUNTY <b>MADISON</b> 13c. CITY OR TOWN <b>LONDON</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>267D SURREY SQ</b>   |  |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PAUL ALLEN RUSH</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY ALICE TAYLOR</b>   |  |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>1965-1980</b>   |  | 17. INFORMANT<br>(WIFE) <b>OK CHA RUSH</b>  |  | ADDRESS<br><b>267D SURREY SQ LONDON, OHIO</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EMBRYONAL CANCER/EMBRYONAL CELL CARCINOMA</b><br><b>1869</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>16 MARCH</b> 19 <b>81</b> to <b>17 APRIL</b> 19 <b>81</b> , that (X) (we) lost<br>saw the deceased alive on <b>17 APRIL</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>C.H. June MD</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>18 APR 1981</b>                                    |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.H. JUNE MD</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>NNMC BETHESDA MD 20014</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE <b>1981</b><br><b>Apr. 22</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Colman Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington Courthouse OHIO</b>  |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>GERSTNER-KINZER WASH.C.H. OHIO</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 22 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ray H. H. H.</b>                         |   |  |  |

MEDICAL CERTIFICATION

BP \_\_\_\_\_



10/10/91

CM - 10/10/91

*[Handwritten signature]*

APR 25 1991

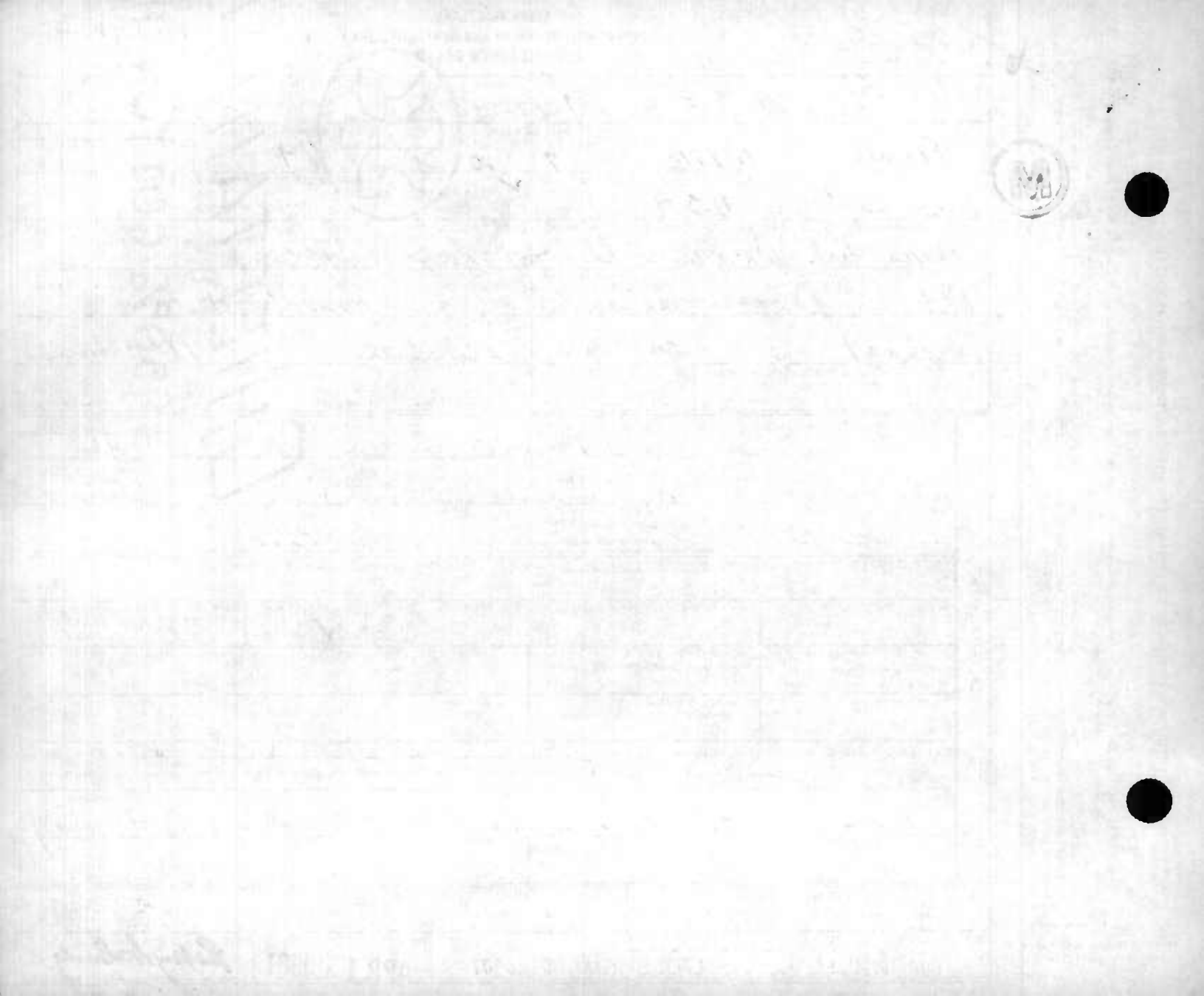
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   | REG. NO.  |  |
|--|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Margaret E RUTLAND</b>   |  |   |  |   | 2b. DATE OF DEATH MONTH <b>4</b> DAY <b>14</b> YEAR <b>81</b> |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>7</b> DAY <b>14</b> YEAR <b>01</b>  |   |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>WASH. D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |  |
| 10 CITY OR TOWN OF DEATH <b>Takoma Park</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON Adventist Hosp</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>   |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>  |  | 13a. STREET ADDRESS <b>4614 SOUTH DAKOTA AVE., N.E.</b>   |   |  |
| 14. FATHER'S NAME FIRST <b>Michael</b> MIDDLE <b>J</b> LAST <b>Sullivan</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Eugabeth</b> MIDDLE <b>Mc</b> LAST <b>Conrich</b>   |  | 13b. STREET ADDRESS <b>XXXXXX XXXXXX XXXXXX</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>579-52-5471</b>   |  | 17 INFORMANT ADDRESS <b>HUGH W. RUTLAND SAME AS 13 HUSBAND</b>  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiogenic Shock.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4hr.</b>      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/14</b> , 19 <b>81</b> , to <b>4/14</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>4/14</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |
| 22b. SIGNATURE <b>Keith Lindgren</b>   |  | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>4/14/81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. KEITH LINDGREN</b>  |  | 22e. ADDRESS <b>7600 CARROLL AVENUE, TAKOMA PARK, MD.</b>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>4/17/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>   |   |  |
| 23d. LOCATION CITY OR TOWN <b>BRENTWOOD</b> COUNTY <b>PRI-GEO</b> STATE <b>MD.</b>   |  | 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>                        |  |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR <b>APR 15 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 1 1 0 1 6   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>PERCY (NMN) Ryland</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 4-13-81 12 <sup>02</sup> P.M.  |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR 10-22-13  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Vendor</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>4715 Aspen Hill Rd.</b>                 |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas J. Ryland</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Garrett</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>577 20 6607</b>  |  | 17. INFORMANT ADDRESS <b>Mrs. Agnes D. Ryland (wife) #13</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dehydration</b><br>2049<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lymphomatous Leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>7 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Jeremy V. Cooke</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>4/13/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeremy V. Cooke</b>   |  |  |  | 22e. ADDRESS <b>10400 Conn. Ave. Kensington MD</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Apr. 16, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATOR <b>Fort Lincoln</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bladensburg, Md.</b>   |  |
| 24. FUNERAL DIRECTOR <b>W.W. Taltavull</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 16 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Robert M. [Signature]</b>   |  |
| 4748 Wisc. Ave. N.W. Wash. D.C. 20016  |  |  |  |   |  |   |  |

XXXXXX  
APR 16 1981  
FBI - NEW YORK

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |   |                            | REG. NO. 11017  |  |
|--|--|------------------|--|--|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lillian Monarch Sachs   |  |                  |  |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>4/16 19 81                               |  |   | 2b. HOUR<br>M<br>8:40 A. M |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sep. 28, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                            | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4/16 19 81                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Russia  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2409 Spencer Road |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----  |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13e. STREET ADDRESS<br>2409 Spencer Road  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Falik Monarch  |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie Williams                      |  |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>-----  |  | 17. INFORMANT ADDRESS<br>Md.<br>Ruth S. Wolfson; 7011 Pyle Rd., Bethesda              |  |   |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic myocardial disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                  |  |  |  |   |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Years                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>None   |  |                  |  |  |  |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION<br>None   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                            | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None |  |   |                            |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |                            |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |                            |   |  |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy   |  |   |  | MEDICAL EXAMINER<br>1919 Seminary Road  |                            |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>John S. Rogers, M.D.  |  |                  |  | ADDRESS<br>Silver Spring, Montgomery, Md.  |  |   |  | DATE SIGNED<br>4/16/81  |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>4-17-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>B'nai Israel Cemetery                           |  |   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Oxon Hill, Maryland                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels;  |  |                  |  | ADDRESS<br>Rockville, Md.<br>1170 Rockville Pike   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>APR 20 1981  |                            | 25b. REGISTRAR'S SIGNATURE  |  |

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326



327

328

329

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 11018   |  |   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Allen Jay Sanderson</b> |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>4/7 19 81</b>                        |  | 2b. HOUR <b>M</b>   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Mar. 10, 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>59 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>4/7 19 81</b>  |  | 2d. HOUR <b>12:32 P. M.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3526 Pear Tree Court, #14</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer- US News &amp; World</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Report</b>                                     |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Montgomery</b>                                  |  | 13c. CITY OR TOWN <b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3526 Pear Tree Court, #14</b>   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Joseph Sanderson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Mary Pulver</b>   |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>WW II 578-42-2029</b>  |  | 17. INFORMANT <b>Sarah F. Sanderson Same as Item # 13</b>                                    |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4291</b> IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>chronic myocardial disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>  |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>None</b>   |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>None</b>   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE   |  |  |  | TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>4/7/81</b>  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>   |  |  |  | ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>   |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |  |  | 23b. DATE <b>Apr. 8, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>                               |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph Gawler's Sons, Inc.</b>  |  |  |  | ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 10 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |



Items 21a thru 22a G5585 5/6/81 dnd  
 1- STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 1 1 1 0 1 9

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence SAUNDERS</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April - 9 - 81</b>                         |   | 2b. HOUR<br>PM<br><b>7.15</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 13, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |   |   | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Potomac</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Platzer</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Murphy</b>                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>            |   | 16b. SOCIAL SECURITY NO.<br><b>578-46-5763</b>  |  | 17. INFORMANT<br><b>Daughter in law</b> ADDRESS<br><b>3512 Brookwood Dr. Fairfax, Va.</b> |   |

|   |  |
|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>3109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRONCHOPNEUMONIA + SEPTICEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC BRAIN SYNDROME WITH</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MINUTES</b><br><b>4 DAYS</b><br><b>8 MONTHS</b> |  |
|---|--|

|   |  |
|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><b>SEMICOMA, APHASIA + CONVULSIONS, SECONDARY TO TRAUMA</b> |  |
|---|--|

|                        |  |  |  |
|------------------------|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 8/80 19</b> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)<br><b>fell down stairs - was intoxicated</b> |  |
|---|--|---|--|

|  |   |  |
|--|---|--|
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b> | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>home Montgomery Co., Md.</b> |
|--|---|--|

|  |  |
|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 1, 1980</b> to <b>April 7, 1981</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |
|--|--|

|   |  |
|---|--|
| 22b. SIGNATURE<br><b>Edward W. Youngblood, M.D.</b> | 22c. DATE SIGNED<br><b>April 9, 1981</b> |
|---|--|

|   |   |
|---|---|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E.W. YOUNGBLOOD</b> | 22e. ADDRESS<br><b>4900 MASS AVE, N.W. WASHINGTON, D.C. 20016</b> |
|---|---|

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b> | 23b. DATE<br><b>April 11, 1981</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria, Virginia</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
|--|------------------------------------|--|--|

|   |   |  |
|---|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1981</b> | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |
|---|---|--|

|   |                                     |
|---|-------------------------------------|
| 26. DATE OF DEATH<br><b>April 9, 1981</b> | 27. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 28. DATE OF DEATH<br><b>April 9, 1981</b> | 29. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 30. DATE OF DEATH<br><b>April 9, 1981</b> | 31. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 32. DATE OF DEATH<br><b>April 9, 1981</b> | 33. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 34. DATE OF DEATH<br><b>April 9, 1981</b> | 35. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 36. DATE OF DEATH<br><b>April 9, 1981</b> | 37. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 38. DATE OF DEATH<br><b>April 9, 1981</b> | 39. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 40. DATE OF DEATH<br><b>April 9, 1981</b> | 41. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 42. DATE OF DEATH<br><b>April 9, 1981</b> | 43. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 44. DATE OF DEATH<br><b>April 9, 1981</b> | 45. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 46. DATE OF DEATH<br><b>April 9, 1981</b> | 47. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 48. DATE OF DEATH<br><b>April 9, 1981</b> | 49. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 50. DATE OF DEATH<br><b>April 9, 1981</b> | 51. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 52. DATE OF DEATH<br><b>April 9, 1981</b> | 53. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 54. DATE OF DEATH<br><b>April 9, 1981</b> | 55. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 56. DATE OF DEATH<br><b>April 9, 1981</b> | 57. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 58. DATE OF DEATH<br><b>April 9, 1981</b> | 59. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 60. DATE OF DEATH<br><b>April 9, 1981</b> | 61. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 62. DATE OF DEATH<br><b>April 9, 1981</b> | 63. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 64. DATE OF DEATH<br><b>April 9, 1981</b> | 65. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 66. DATE OF DEATH<br><b>April 9, 1981</b> | 67. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 68. DATE OF DEATH<br><b>April 9, 1981</b> | 69. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 70. DATE OF DEATH<br><b>April 9, 1981</b> | 71. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 72. DATE OF DEATH<br><b>April 9, 1981</b> | 73. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 74. DATE OF DEATH<br><b>April 9, 1981</b> | 75. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 76. DATE OF DEATH<br><b>April 9, 1981</b> | 77. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 78. DATE OF DEATH<br><b>April 9, 1981</b> | 79. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 80. DATE OF DEATH<br><b>April 9, 1981</b> | 81. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 82. DATE OF DEATH<br><b>April 9, 1981</b> | 83. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 84. DATE OF DEATH<br><b>April 9, 1981</b> | 85. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 86. DATE OF DEATH<br><b>April 9, 1981</b> | 87. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 88. DATE OF DEATH<br><b>April 9, 1981</b> | 89. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 90. DATE OF DEATH<br><b>April 9, 1981</b> | 91. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 92. DATE OF DEATH<br><b>April 9, 1981</b> | 93. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 94. DATE OF DEATH<br><b>April 9, 1981</b> | 95. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 96. DATE OF DEATH<br><b>April 9, 1981</b> | 97. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| 98. DATE OF DEATH<br><b>April 9, 1981</b> | 99. TIME OF DEATH<br><b>7:15 PM</b> |
|---|-------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 100. DATE OF DEATH<br><b>April 9, 1981</b> | 101. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 102. DATE OF DEATH<br><b>April 9, 1981</b> | 103. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 104. DATE OF DEATH<br><b>April 9, 1981</b> | 105. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 106. DATE OF DEATH<br><b>April 9, 1981</b> | 107. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 108. DATE OF DEATH<br><b>April 9, 1981</b> | 109. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 110. DATE OF DEATH<br><b>April 9, 1981</b> | 111. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 112. DATE OF DEATH<br><b>April 9, 1981</b> | 113. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 114. DATE OF DEATH<br><b>April 9, 1981</b> | 115. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 116. DATE OF DEATH<br><b>April 9, 1981</b> | 117. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 118. DATE OF DEATH<br><b>April 9, 1981</b> | 119. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 120. DATE OF DEATH<br><b>April 9, 1981</b> | 121. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 122. DATE OF DEATH<br><b>April 9, 1981</b> | 123. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 124. DATE OF DEATH<br><b>April 9, 1981</b> | 125. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 126. DATE OF DEATH<br><b>April 9, 1981</b> | 127. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 128. DATE OF DEATH<br><b>April 9, 1981</b> | 129. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 130. DATE OF DEATH<br><b>April 9, 1981</b> | 131. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 132. DATE OF DEATH<br><b>April 9, 1981</b> | 133. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 134. DATE OF DEATH<br><b>April 9, 1981</b> | 135. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 136. DATE OF DEATH<br><b>April 9, 1981</b> | 137. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 138. DATE OF DEATH<br><b>April 9, 1981</b> | 139. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 140. DATE OF DEATH<br><b>April 9, 1981</b> | 141. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 142. DATE OF DEATH<br><b>April 9, 1981</b> | 143. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 144. DATE OF DEATH<br><b>April 9, 1981</b> | 145. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 146. DATE OF DEATH<br><b>April 9, 1981</b> | 147. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 148. DATE OF DEATH<br><b>April 9, 1981</b> | 149. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 150. DATE OF DEATH<br><b>April 9, 1981</b> | 151. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 152. DATE OF DEATH<br><b>April 9, 1981</b> | 153. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 154. DATE OF DEATH<br><b>April 9, 1981</b> | 155. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 156. DATE OF DEATH<br><b>April 9, 1981</b> | 157. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 158. DATE OF DEATH<br><b>April 9, 1981</b> | 159. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 160. DATE OF DEATH<br><b>April 9, 1981</b> | 161. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 162. DATE OF DEATH<br><b>April 9, 1981</b> | 163. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 164. DATE OF DEATH<br><b>April 9, 1981</b> | 165. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 166. DATE OF DEATH<br><b>April 9, 1981</b> | 167. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 168. DATE OF DEATH<br><b>April 9, 1981</b> | 169. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 170. DATE OF DEATH<br><b>April 9, 1981</b> | 171. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 172. DATE OF DEATH<br><b>April 9, 1981</b> | 173. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 174. DATE OF DEATH<br><b>April 9, 1981</b> | 175. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 176. DATE OF DEATH<br><b>April 9, 1981</b> | 177. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 178. DATE OF DEATH<br><b>April 9, 1981</b> | 179. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 180. DATE OF DEATH<br><b>April 9, 1981</b> | 181. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 182. DATE OF DEATH<br><b>April 9, 1981</b> | 183. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 184. DATE OF DEATH<br><b>April 9, 1981</b> | 185. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 186. DATE OF DEATH<br><b>April 9, 1981</b> | 187. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 188. DATE OF DEATH<br><b>April 9, 1981</b> | 189. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 190. DATE OF DEATH<br><b>April 9, 1981</b> | 191. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 192. DATE OF DEATH<br><b>April 9, 1981</b> | 193. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 194. DATE OF DEATH<br><b>April 9, 1981</b> | 195. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 196. DATE OF DEATH<br><b>April 9, 1981</b> | 197. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 198. DATE OF DEATH<br><b>April 9, 1981</b> | 199. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 200. DATE OF DEATH<br><b>April 9, 1981</b> | 201. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 202. DATE OF DEATH<br><b>April 9, 1981</b> | 203. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 204. DATE OF DEATH<br><b>April 9, 1981</b> | 205. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 206. DATE OF DEATH<br><b>April 9, 1981</b> | 207. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

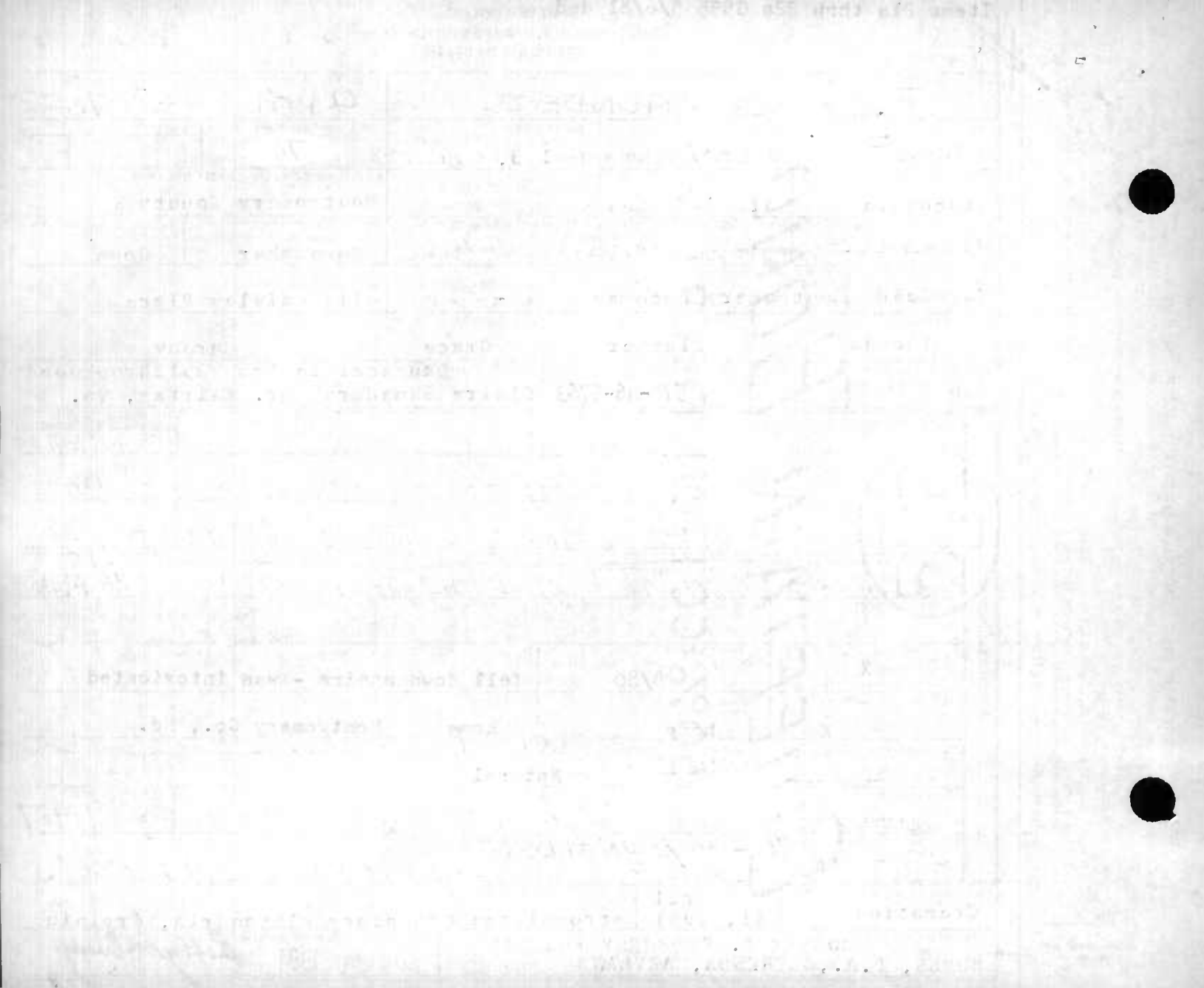
|  |                                      |
|--|--------------------------------------|
| 208. DATE OF DEATH<br><b>April 9, 1981</b> | 209. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 210. DATE OF DEATH<br><b>April 9, 1981</b> | 211. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |                                      |
|--|--------------------------------------|
| 212. DATE OF DEATH<br><b>April 9, 1981</b> | 213. TIME OF DEATH<br><b>7:15 PM</b> |
|--|--------------------------------------|

|  |
|--|
|  |
|--|





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |   |   |  |
|--|--|---|--|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  | REG. NO.   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Ruth C Schmidt</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>4-2-81</b>   |  |   | 2b. HOUR <b>7:29</b> M  |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Cauc</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>3 4 1882</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD                       |   |   |  |
| 10 CITY OR TOWN OF DEATH <b>Gaithersburg</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Herman Wilson Health Care</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>   |  |   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>201 Russell Ave.</b>   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George Hook</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen L. Munson</b>  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO <b>220-16-2744A</b>   |  | 17 INFORMANT ADDRESS <b>141 Greenberry Rd. Hagerstown, Md. 21740</b><br><b>Mrs. E. Harriman</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest.</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Congestive heart failure</b><br>(c) <b>Arteriosclerotic heart disease</b> |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 min.</b><br><b>1 mo.</b><br><b>2 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diverticulitis, Chronic brain syndrome, osteoporosis</b>  |  |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 1976</b> to <b>April 2, 1981</b> , that (1) (we) lost the deceased alive on <b>March 9, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.                               |  |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE <b>James R. Moore Jr. MD</b> DEGREE <b>MD</b>   |  |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED <b>4-3-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Moore Jr. MD</b>   |  |   |  |  | 22e. ADDRESS <b>207 Brookes Ave Gaithersburg Md.</b>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>4/6/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Winchester Frederick Md.</b>        |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Gartner Sandison F. H. Gaithersburg, Md.</b> ADDRESS <b>316 E. Diamond Ave.</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 8 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |  |



101 Russell Ave.

Postmaster: Please return to

Mr. J. J. Harrison  
101 Russell Ave.  
New York, N. Y.

Mr. J. J. Harrison

No.

Mr. J. J. Harrison  
101 Russell Ave.  
New York, N. Y.  
Mr. J. J. Harrison  
101 Russell Ave.  
New York, N. Y.  
Mr. J. J. Harrison  
101 Russell Ave.  
New York, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |   |  |  |   |  |                             |
|---|--|---|--|--|---|--|--|---|--|-----------------------------|
| 1- FOR STATE REGISTRAR  |  |   |  |  | REG. NO.  |  |  |   |  |                             |
| 1. DECEASED NAME (TYPE OR PRINT) <b>RAE</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>April 11 1981</b>       |  |  |   |  | 2b. HOUR <b>3:00 P.M.</b>   |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>July 1 1907</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                   |  |   |  |                             |
| 10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary (Ret.)</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>   |  |                             |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>SILVER SPRING</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>15025 WELLWOOD RD.</b>   |  |                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Isidore Nadler</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(unknown)</b> |  |  |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>107-22-8486</b>   |  | 17. INFORMANT ADDRESS <b>Silver Spring, Md.</b><br><b>Col. Joel I. Schwab; 15025 Wellwood Road</b>   |   |  |  |   |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe volume depletion</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Systemic lupus erythematosus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic brain syndrome</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |   |  |  |   |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |   |  |  |   |  |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |   |  |                             |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |                             |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>January 4 1981</b> to <b>4 11 1981</b> , that (1) (we) last saw the deceased alive on <b>4 11 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) (we did not) (we did not) view the body after death.   |  |   |  |  |   |  |  |   |  |                             |
| 22b. SIGNATURE <b>Mark S Rosen</b>  |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 22c. DATE SIGNED <b>4-12-81</b>  |  |   |  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark S Rosen</b>   |  |   |  | 22e. ADDRESS <b>Silver Spring, Md.</b>   |   |  |  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>4-13-1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cemetery</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elmont, New York</b>                              |  |   |  |                             |
| 24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 13 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |                             |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 11022                                |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>ERMINIA ROSSI SCIARRINO</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>April 30 1981</b>  |  |
| 1. SEX <b>F</b> 4. RACE <b>W</b> 5. DATE OF BIRTH <b>NOV 15 1918</b> 6. AGE (IN YEARS) <b>62</b> 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 7c. DATE PRONOUNCED DEAD <b>April 30 1981</b>  |  |  |  |  |  |  |  |  |  | 2b. DATE KNOWN OF DEATH <b>April 30 1981</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CONNECTICUT</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>April 30 1981</b> |  |
| 10. CITY OR TOWN OF DEATH <b>Sil Spg</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PASSPORT CLERK U.S. DEPT OF STAT</b> 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  | 2d. DATE PRONOUNCED DEAD <b>April 30 1981</b> |  |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>Mont</b> 13c. CITY OR TOWN <b>Sil Spg</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>12232 Cedar Hill Dr.</b>   |  |  |  |  |  |  |  |  |  | 2e. DATE PRONOUNCED DEAD <b>April 30 1981</b> |  |
| 14. FATHER'S NAME <b>JOSEPH ROSSI</b> 15. MOTHER'S MAIDEN NAME <b>PIA UNKNOWN</b>  |  |  |  |  |  |  |  |  |  | 2f. DATE PRONOUNCED DEAD <b>April 30 1981</b> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b> 16b. SOCIAL SECURITY NO. <b>044-07-4772</b> 17. INFORMANT <b>FRANK N. SCIARRINO</b> ADDRESS <b>SAME AS 13 HUSBAND</b>   |  |  |  |  |  |  |  |  |  | 2g. DATE PRONOUNCED DEAD <b>April 30 1981</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4291</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. <b>Dep</b> MEDICAL EXAMINER DATE SIGNED <b>April 30 1981</b>   |  |  |  |  |  |  |  |  |  |   |  |
| EXAMINER'S NAME <b>JOHN S. ROGERS</b> ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>May 5, 1981</b> 23c. NAME OF CEMETERY OR CREMATORY <b>MT. ST. PETERS CEMETERY</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>DERBY NEW HAVEN CT.</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b> 25a. DATE REC'D. BY REGISTRAR <b>MAY 4 1981</b> 25b. REGISTRAR'S SIGNATURE <b>Peter J. Collins</b>  |  |  |  |  |  |  |  |  |  |   |  |

11

DOWN

1901 1 Y 211



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death.

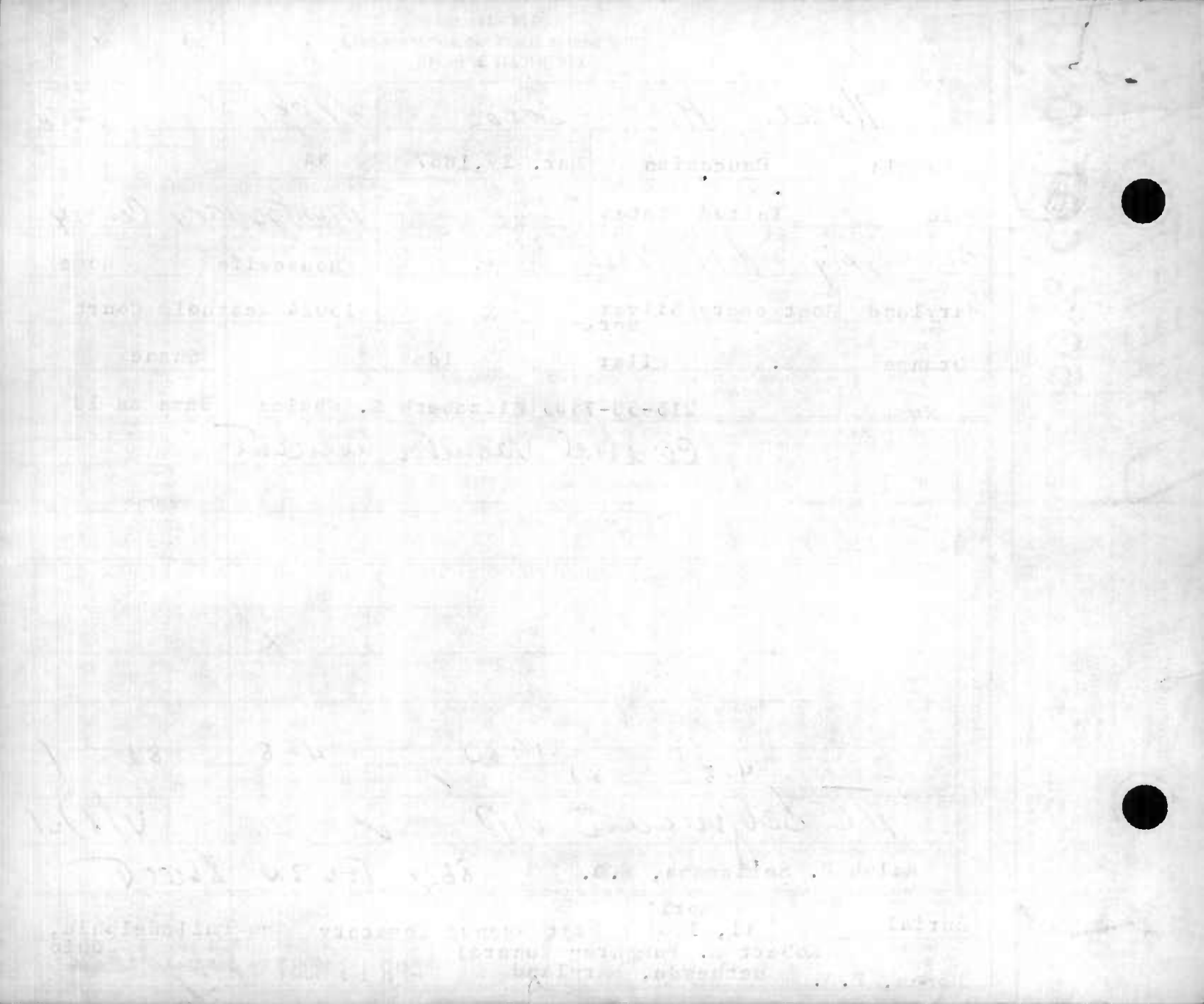
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nazel M. Seeds</b>   |  |  |  |   |  |  |  |   |  | 3a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/8/81</b>  |  | 2b. HOUR<br><b>2:55 A</b> M                        |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 29, 1887</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>94</b>   |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>24</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                 |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b>   |  |  |  |   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>15024 Westholm Court</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Orange E. Milar</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Shane</b>   |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-58-7505</b>   |  | 17. INFORMANT<br><b>Elizabeth S. Whalen</b>   |  |  |  | ADDRESS<br><b>Same as 13</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vasculature Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____  |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> 19 <b>4-8</b> to <b>4-8</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-8-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death. |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R E Seligmann</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>4/8/81</b>   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ralph E. Seligmann, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>8620 FENTON Street</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 11, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>East Avenue Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>New Philadelphia, Ohio</b>          |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |  |   |  |  |  |

MEDICAL CERTIFICATION

29

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KATHERINE SEEGER</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 6 1981</b>  |  | 2b. HOUR<br><b>7<sup>50</sup> A M</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 24 1879</b>                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>101</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ins. Co.</b>                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Lutheran Home</b>                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN<br><b>Frederick</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Seeger</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Woerner</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-10-1691</b>  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 17b. SOCIAL SECURITY NO.<br><b>214-10-1691</b>  |  | 17c. STREET ADDRESS<br><b>413 E. Patrick Street</b>                                  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Valvular Heart Disease</b>   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>4860</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Chronic Valvular Heart Disease</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 16, 1961</b> to <b>April 6, 1981</b> , that (I) (we) lost saw the deceased alive on <b>April 5, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Harold F.M. Carrn</b>   |  |   |  | 22c. DATE SIGNED<br><b>April 6, 1981</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Harold F.M. Carrn</b>  |  |   |  | 22e. ADDRESS<br><b>Rockville, Maryland 20850</b>                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Apr. 9, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>                         |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Madelay Keeney Bassford</b>  |  |  |  |
| 24. FUNERAL HOME<br>ADDRESS<br><b>106 E. Church St., Frederick, Md. 21701</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 9 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Kathy McCreedy</b>                                  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                         |   |   | 8 1 1 0 2 5  |   |
|--|-------------------------|---|---|--|---|
| 1. FOR STATE REGISTRAR   |                         |   |   | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE E. SEPURE</b>   |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-23-81</b>           |  | 2b. HOUR<br><b>9:55 AM</b>                                      |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 27 1892</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Potomac Valley Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   |
| 13a. STATE<br><b>Maryland</b>  |                         |   | 13b. COUNTY<br><b>Montgomery</b>                                | 13c. CITY OR TOWN<br><b>Rockville</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adam</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>264-82-5093</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy C. Poole same as 13c</b>                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |                         |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.<br><b>5 days.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Generalized Arteriosclerosis - Cerebrovascular Thrombosis</b>   |                         |   |   |  |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/23/81</b> , 19____, to <b>4/23/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/23/81</b> , 19____, and that in (my) (our) opinion death occurred on this date and hour and from the causes stated above. (I) (we) (did) (do) not view the body after death. |                         |   |   |  |   |
| 22b. SIGNATURE<br><b>Henry C. Seeger MD.</b>   |                         | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>4/23/81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henry C. Seeger MD.</b>  |                         | 22e. ADDRESS<br><b>5413 Cedar Lane Bethesda Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>4/25/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>                  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b>   |                         | 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b>                               |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1981</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Henry C. Seeger</b>  |   |  |   |

(11)

Germany USA X Montgomery

Rockville

Potomac Valley Hospital Home

Rockville

Home

Maryland

Montgomery Rockville

X

Rockville Home

Adam

Arnold

Unknown

no

504-02-5005 Dorothy C. Poole same as 1 a

1951 Rockville Pike Rockville, Maryland  
Tynon Heeler Funeral Home, Inc.  
Burial W/5/51 Parklawn Memorial Park Rockville, Maryland

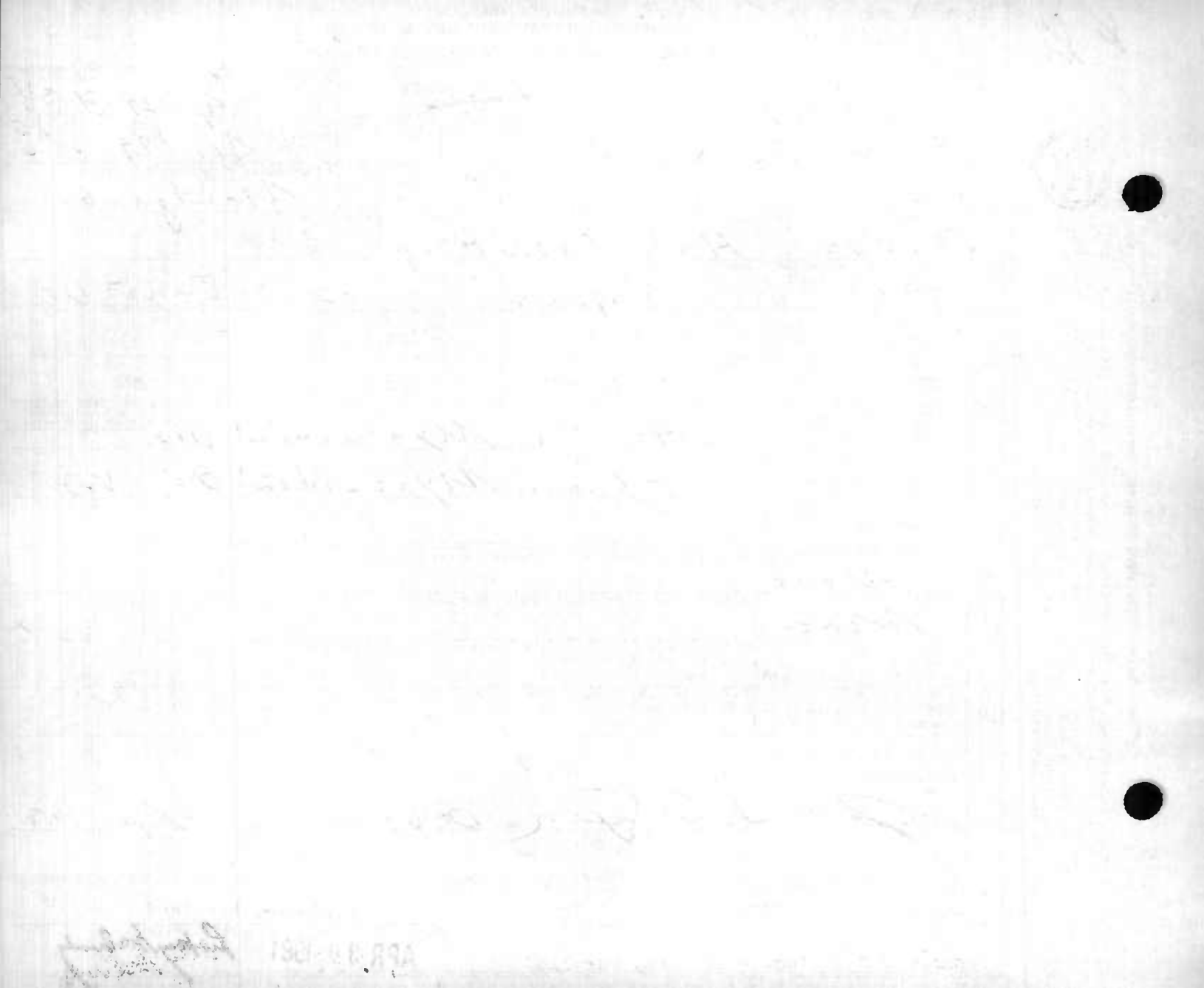
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

|  |  |                  |                         |  |  |   |  |   |  |   |  |
|--|--|------------------|-------------------------|--|--|---|--|---|--|---|--|
| Item #1 per phone call w/ Fun. Hom. STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |                         |  |  |   |  |   |  | REG. NO. 11026  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Mary</u> MIDDLE <u>N</u> LAST <u>Sessa</u>   |  |                  |                         |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <u>April 29</u> 19 <u>81</u> MONTH DAY YEAR |  |
| 3. SEX <u>F</u>  |  | 4. RACE <u>W</u> |                         | 5. DATE OF BIRTH MONTH DAY YEAR <u>Sept 10</u> <u>13</u> <u>67</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS.                                |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <u>April 29</u> 19 <u>81</u> MONTH DAY YEAR          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>  |  |                  |                         | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.                    |  |
| 10. CITY OR TOWN OF DEATH <u>P.O. Spg.</u>   |  |                  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hosp</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. CITY OR TOWN <u>Harf. Edgewood</u>   |  |                  |                         | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS <u>1219 Janet Dr.</u>                                     |  |   |  |   |  |
| 14. FATHER'S NAME FIRST <u>Thomas</u> MIDDLE <u>xxx</u> LAST <u>Vain</u>   |  |                  |                         | 15. MOTHER'S MAIDEN NAME FIRST <u>Alice</u> MIDDLE <u>?</u> LAST <u>?</u>  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>   |  |                  |                         | 16b. SOCIAL SECURITY NO. <u>213-30-5070</u>  |  | 17. INFORMANT <u>Mr Peter G Sessa</u> ADDRESS <u>Same</u>                     |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u><br>(b) <u>Chronic Myocardial Dis.</u><br>(c) <u>4291</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |                         |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Yrs</u>                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                         |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <u>None</u><br>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                  |                         |  |  |   |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |                         |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Phil Sessa</u>   |  |                  |                         | TITLE (SPECIFY) <u>M.D. Dep.</u> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <u>April 29/1981</u>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS  |  |                  |                         |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  |                  | 23b. DATE <u>5/2/81</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> |   |  | 23d. LOCATION CITY OR TOWN <u>Baltimore, Maryland</u> COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Leonard J Ruck Inc.</u> ADDRESS <u>Baltimore, Maryland</u>  |  |                  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR <u>APR 30 1981</u>                              |  | 25b. REGISTRAR'S SIGNATURE <u>Robert H. H. H.</u>   |  |   |  |



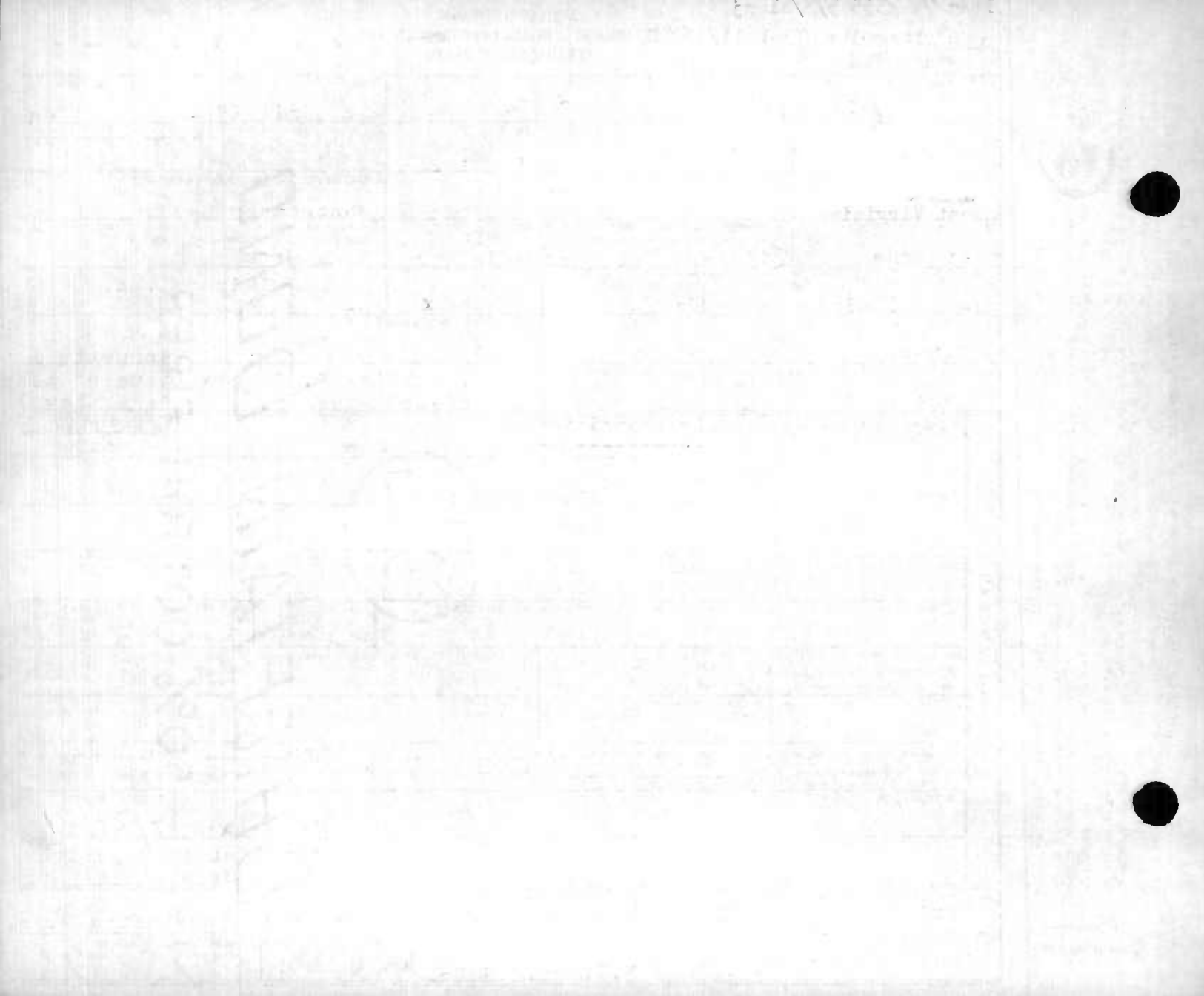


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |
| REG. NO.   |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAULINE MAE SHEETS</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>27 April 1981</b>  |  | 2b. HOUR<br><b>2:20 AM</b>   |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 19, 1926</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>54</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Clinical Ctr, Bethesda, MD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |
| 13a. STATE<br><b>West Virginia</b>   |  |  |  |   | 13b. CITY OR TOWN<br><b>UNK Kirby</b>  |  | 13c. STREET ADDRESS<br><b>Kirby, W.Va. 26729</b>   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gilbert Dahmer</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nola Bennett</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>236-38-1005</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Mr. William B. Sheets (Same as Patient's Husband Same Above)</b>                             |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lymphangitic Lymphatic Pulmonary Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Breast Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1749</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>April 13, 1981</b> to <b>April 27, 1981</b> that (we) lost saw the deceased alive on <b>April 27, 1981</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (it) (they) (the body) after death.   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>G.A. CURT</b>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>4/27/81</b>                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G.A. CURT</b>  |  |  |  |   | 22e. ADDRESS<br><b>National Institutes of Health, Clinical Center, Bethesda, MD 20205</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>4/29/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbovale Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbovale Pochahontas W.Va.</b>      |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hines/Ri naldi F.H.11800 N.H.Ave.S.S.Md.</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

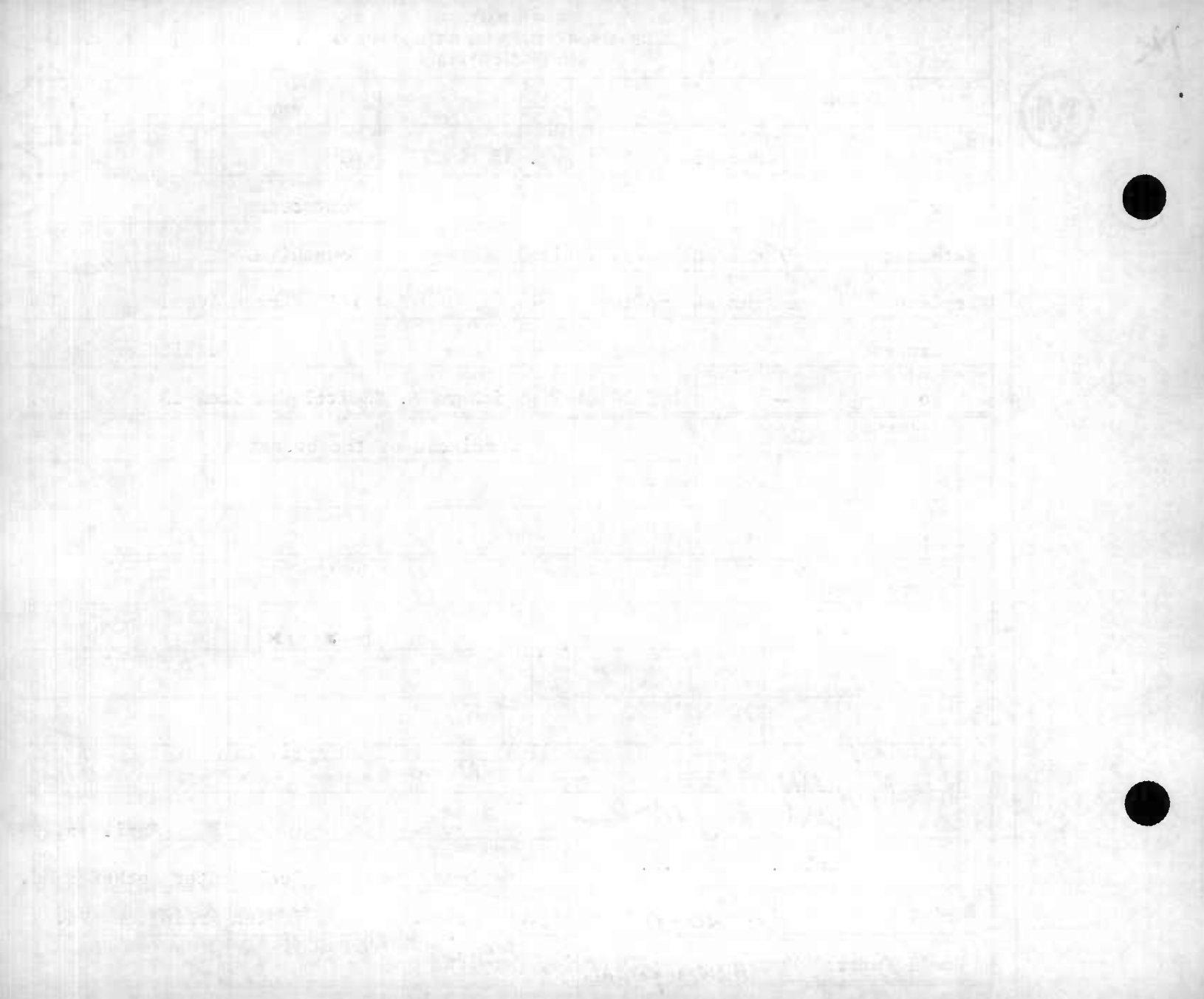
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

MEDICAL CERTIFICATION

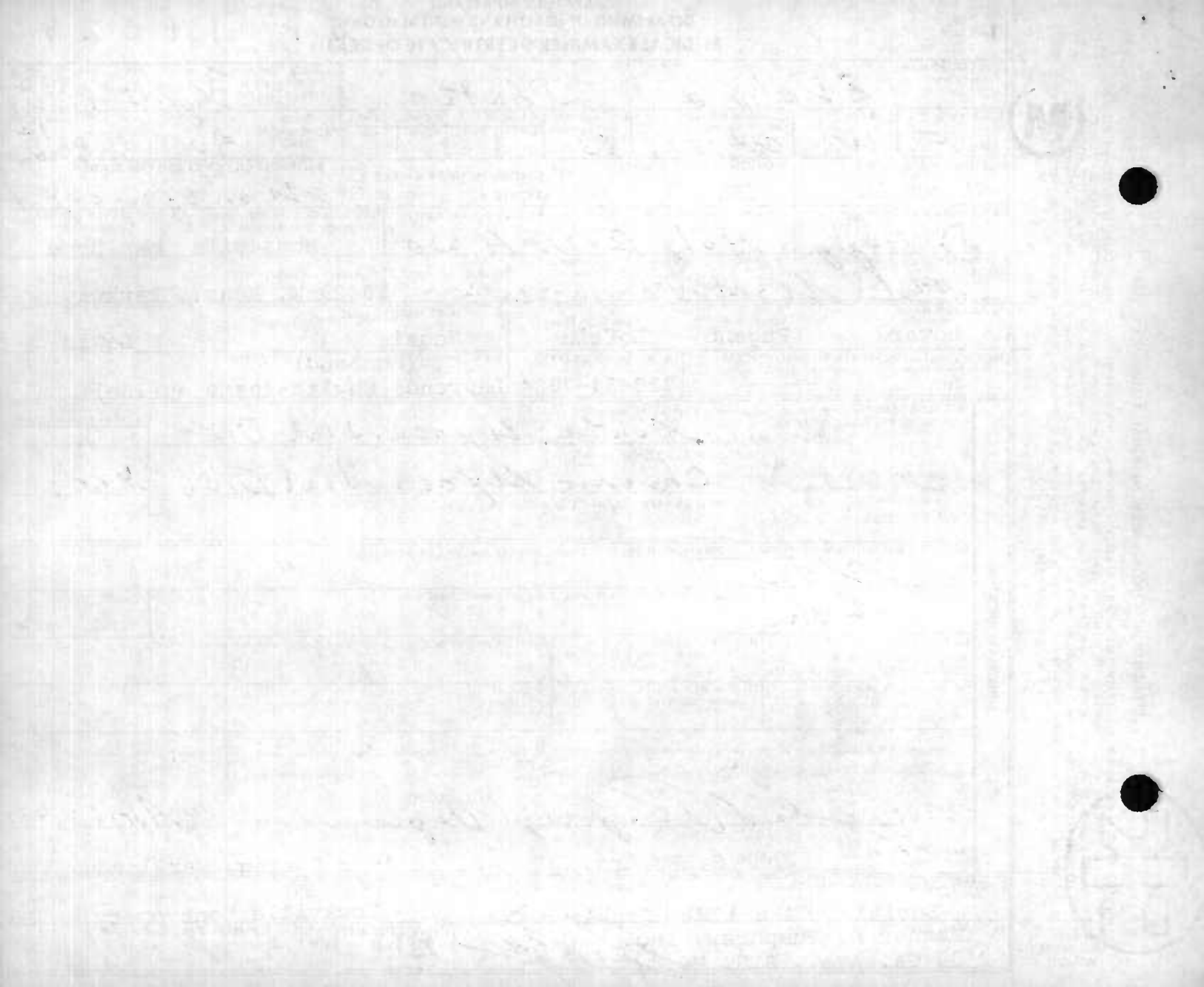
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |
| REG. NO.   |  |   |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Suzanne Sheftel</b>  |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR 2b HOUR<br><b>April 15 1981 2:40P</b> <small>AM</small>  |  |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 13 1931</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> <small>MD.</small>                    |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Maryland</b> 13b COUNTY <b>Anne Arundel</b> 13c CITY OR TOWN <b>Crofton</b>  |  |   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br><b>1453 Harrow Avenue</b>      |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Phaneuf</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Schlittler</b>  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>109 24 6481</b>  |  | 17 INFORMANT ADDRESS<br><b>Richard A. Sheftel See item 13</b>  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1749</b> IMMEDIATE CAUSE (a) <b>Carcinoma of the breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Hypercalcemia</b>   |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>April 4 19 81</b> , to <b>April 15 19 81</b> , that (i) (we) lost<br>saw the deceased alive on <b>April 15 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (i) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Carl H. June</b>  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>April 16, 1981</b>            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carl H. JUNE, M.D.</b>   |  |   |  |  | 22e. ADDRESS<br><b>National Naval Medical Center Bethesda, Md.</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-20-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Arlington Va.</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Beall Funeral Home</b>  |  |   |  |  | ADDRESS<br><b>161600 Annapolis Rd. Bowie, Maryland</b>   |  | 25. DATE RECEIVED BY REGISTRAR<br><b>APR 20 1981</b> |  |  |
|  |  |   |  |  |  |  | 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>      |  |  |

BP.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                     |   |   |  |                             |   |  |   |  | REG. NO. 11029  |  |
|--|---------------------|---|---|--|-----------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Evelina Shultz</i>   |                     |   |   |  |                             |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>EST. MONTH DAY YEAR HOUR<br><i>April 15 1981 3:30 PM</i> |  |
| 3. SEX<br><i>F</i>   | 4. RACE<br><i>W</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Oct 17 1963</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i> YRS. | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR HOUR<br><i>April 15 1981 3:30 PM</i> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery MD</i>                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Wisconsin</i>  |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife own home</i> |                             |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>St. Louis</i>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hosp</i>                           |   |  |                             | 13a. STATE<br><i>MD</i>   |  |   |  | 13b. COUNTY<br><i>Montgomery</i>  |  |
| 13c. CITY OR TOWN<br><i>Rockville</i>  |                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><i>10429 N. Kens., Parkway</i>                                      |                             |   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Howard Eugene Loftin</i>  |                     |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bessie Lewis</i>                       |                             |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><i>no</i>  |                     | 16b. SOCIAL SECURITY NO.<br><i>220-34-7984</i>  |   | 17. INFORMANT (husband) ADDRESS<br><i>Lawrence Shultz-(same as 13e)</i>                    |                             |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i>Chronic Myocardial Dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>4291</i>   |                     |   |   |  |                             |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>hrs.</i>                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>None</i>   |                     |   |   |  |                             |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |                     |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                             |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)              |                             |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                             |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |   |   |  |                             |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>  |                     |   |   | TITLE (SPECIFY)<br><i>D.M.E.</i>   |                             |   |  | DATE SIGNED<br><i>April 15 1981</i>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><i>John S. Rogers, DME</i>  |                     |   |   | ADDRESS<br><i>Silver Spring, Maryland</i>  |                             |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |                     | 23b. DATE<br><i>4-8-1981</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn Cemetery</i>                             |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Rockville Montgomery Md</i>    |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Warner E. Pumphrey, Inc.</i>  |                     |   |   |  |                             | 25. REC'D. BY REGISTRAR<br><i>APR 15 1981</i>                                   |  | 25a. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |  |   |  |
| 8434 Ga. Ave., S.S. Md   |                     |   |   |  |                             |   |  |   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 1 0 3 0  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ABRAHAM SILVER</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 16, 1981</b>  |  | 2b. HOUR<br><b>12:10<sup>a</sup></b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 25, 1901</b>   |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b> YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Potomac</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11518 Gauguin Lane</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager (Ret)</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Supply Plumbing</b>  |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Montgomery</b>   |  | 13c CITY OR TOWN<br><b>Bethesda</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Samuel Silver</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Esther Litskey</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>579-01-8299</b>   |  | 17 INFORMANT ADDRESS<br><b>Larry Silver; 11518 Gauguin Lane Potomac, Md.</b>   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b><br><b>7 YEARS</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19____, to <b>APRIL 16</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>APRIL 15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Saul Zuckerman MD</b>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>4-16-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAUL ZUCKERMAN, M.D.</b>  |  |   |  | 22e ADDRESS<br><b>5410 Connecticut Ave., NW, Wash, DC</b>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>4-17-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nat'l. Memorial Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Falls Church, Virginia</b>   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Chapels;</b>  |  |   |  | ADDRESS<br><b>1170 Rockville Pike Rockville, Md.</b>   |  |  |  |
| DATE REQUIRED BY REGISTRAR<br><b>APR 20 1981</b>  |  |   |  | REGISTRAR'S SIGNATURE  |  |  |  |

NO. 100 202

X  
M  
12/15/50

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |   |   |  |            |
|---|--|---|--|---|--|---|---|---|--|------------|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |   |   |   |  |            |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |   |  |            |
| REG. NO.  |  |   |  |   |  |   |   |   |  |            |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH  |   |   |   |  | 2b. HOUR   |
| MAMIE J Simms   |  |   |  |   | 4-19-81  |   |   |   |  | 12:10 P.M. |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | IF UNDER 1 YEAR   |  |            |
| FEMALE  |  | Black   |  | MONTH DAY YEAR<br>1 03 1900   |  | 81 YRS.   |   | MONTHS DAYS HOURS MIN.  |  |            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |   |  |            |
| North Carolina  |  | U.S.A.  |  |   |  | Montgomery MD.  |   |   |  |            |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |            |
| Silver Spring   |  | Holy Cross Hospital   |  |   |  | Navy Dept.  |   |   |  |            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS   |  |            |
| D.C.  |  | COUNTY  |  | Washington  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 165 V Street, N.E.  |  |            |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |            |
| FIRST MIDDLE LAST<br>A. B. Jones  |  |   |  |   | FIRST MIDDLE LAST<br>Dolie Shaw  |   |   |   |  |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS                         |   |  |            |
| no  |  |   |  |   | Unknown  |   | Ulysses Curie 7315 Calder St. Capitol Hts, MD |   |  |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |   |   |  |            |
| IMMEDIATE CAUSE (a) Acute CVA   |  |   |  |   |  |   |   |   |  |            |
| 4292 DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |   |  |            |
| (b) Sick Sinus Syndrome   |  |   |  |   |  |   |   |   |  |            |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |   |   |  |            |
| (c) Cardiac arrhythmias   |  |   |  |   |  |   |   |   |  |            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):  |  |   |  |   |  |   |   |   |  |            |
| ASCVD, HF, Anemia   |  |   |  |   |  |   |   |   |  |            |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |            |
| None  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |            |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |   |  |            |
| No  |  | P.M. 19   |  |   |  |   |   |   |  |            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |            |
|   |  |   |  |   |  |   |   |   |  |            |
| 22a. I certify that (1) the hospital attended the deceased from 1-33-81, 19, to 4-19-81, 19, that (1) lost saw the deceased alive on 4-19-81, 19, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (did) view the body after death. |  |   |  |   |  |   |   |   |  |            |
| 22b. SIGNATURE  |  |   |  |   | DEGREE   |   |   | 22c. DATE SIGNED  |  |            |
| MB Patrick III MD   |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 4-19-81   |  |            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   | 22e. ADDRESS   |   |   |   |  |            |
| G B Patrick III MD  |  |   |  |   | 9221 Colesville Rd<br>Silver Spring, MD 20910  |   |   |   |  |            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |   |  |            |
| Burial  |  | Apr. 24, 1981   |  | Jones Cemetery  |  | Whiteville, North Carolina  |   |   |  |            |
| 24. FUNERAL DIRECTOR'S NAME   |  |   |  |   | 24b. ADDRESS   |   | 24c. DATE REC'D. BY REGISTRAR                 |   |  |            |
| Rollins Funeral Home, Inc.  |  |   |  |   |  |   | APR 23 1981                                   |   |  |            |
| 4339 Hunt Pl. N.E., Washington, D.C.  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE   |   |   |   |  |            |

MEDICAL CERTIFICATION

200-1

12-11-10

12-11-10

12-11-10

AVJ 10 H

12-11-10

OM II 12-11-10

OM II 12-11-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

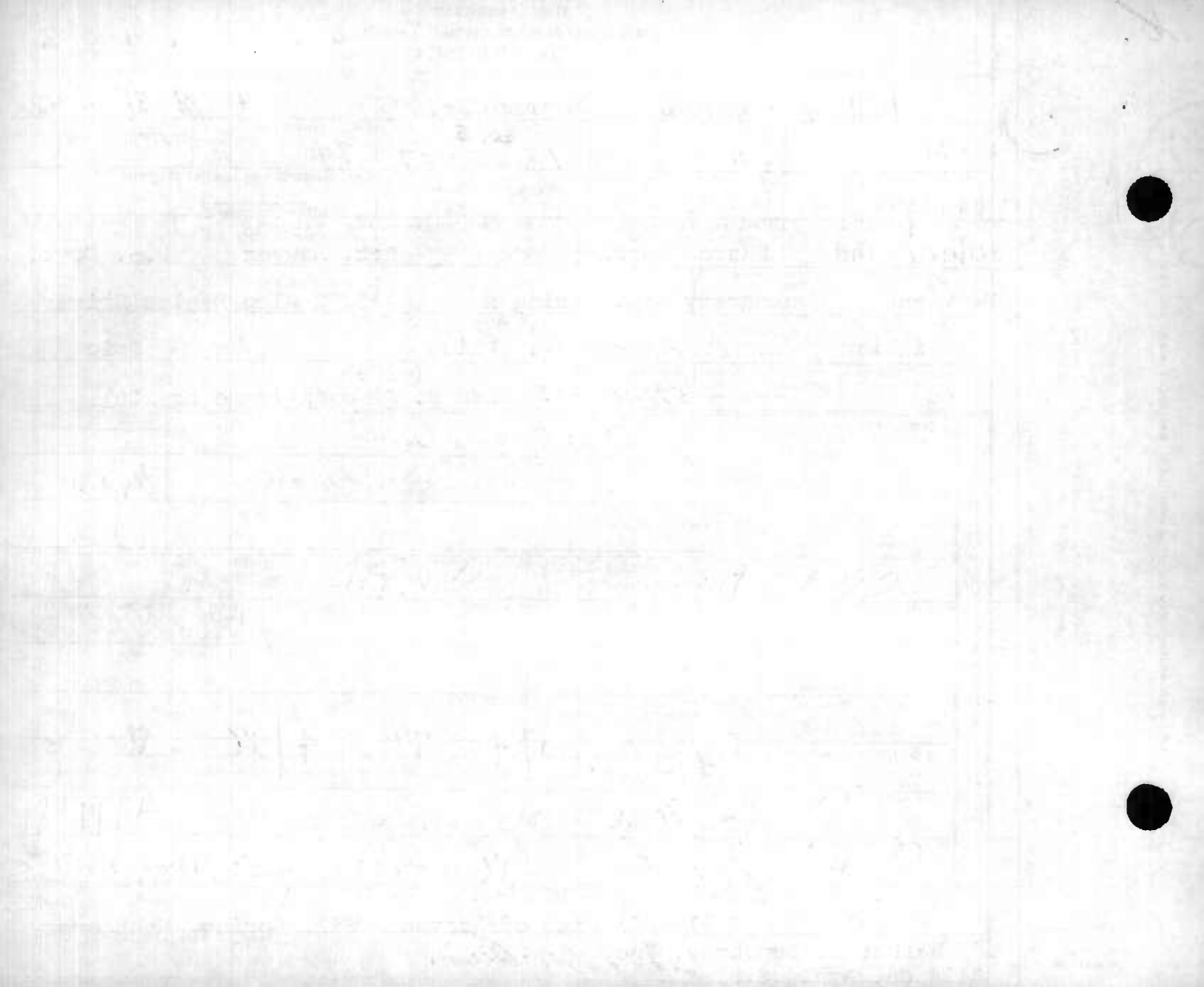
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

4/19/81

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   |   |   |   |  |   |  | 8 1 1 0 3 2                                  |  |
|--|--|---|---|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | CERTIFICATE OF DEATH  |   |  |   |  | REG. NO.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>William Reuben Simpson, Jr.  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>4 18 81                     |   | 2b. HOUR<br>11:48 AM   |   |  |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>W  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 1 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                            |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Olney Md.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sharon Nursing Home |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Lawyer      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.,  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br>Maryland  |  |   |   |   | 13c. CITY OR TOWN<br>Montgomery                                 |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>3492 Glen Eagles Drive,                         |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William R. Simpson, Sr.   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice Spic        |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  |   | 16b. SOCIAL SECURITY NO.<br>577-20-5082                             |   | 17. INFORMANT (wife) ADDRESS<br>Helen B. Simpson--(same as 13e) |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).<br>4092 Cardiac arrest.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b).<br>Dilated CV Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c).<br>years |  |   |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>CV A c thrombosis, D.D.  |  |   |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/13/81 to 4/18/81, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.                                  |  |   |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br>C. H. Ligon  |  |   |   |   |   | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>4/19/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. H. Ligon   |  |   |   |   |   | 22e. ADDRESS<br>1811 P. Philip St., Olney, Md., 20832                             |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>4-21-1981  |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven                              |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Sil. Spring, Montgomery Md. |  |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.  |  |   |   |   |   | 25a. DATE RECD. BY REGISTRAR<br>APR 22 1981                                       |  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                              |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2700

DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | REG. NO.                                     |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST <u>ELEANOR</u> MIDDLE <u>T.</u> LAST <u>SINGER</u>  |  | 2a. DATE OF DEATH  |  | MONTH <u>4</u> DAY <u>2</u> YEAR <u>81</u>   |  | 2b. HOUR  |  | <u>5:55</u> PM                               |  |
| 3 SEX<br><u>Female</u>   |  | 4 RACE<br><u>White</u>  |  | 5 DATE OF BIRTH  |  | MONTH <u>11</u> DAY <u>12</u> YEAR <u>10</u>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                          |  | 70 YRS                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>New York</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery Co</u> MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Gaithersburg</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Herman Wilson Health Care</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Housewife</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>   |  |   |  |  |  |
| 13a. STATE<br><u>Md.</u>   |  | 13b. COUNTY<br><u>Montgomery</u>  |  | 13c. CITY OR TOWN<br><u>Chevy Chase</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><u>2810 Washington Ave.</u>      |  |  |  |
| 14 FATHER'S NAME<br>FIRST <u>FRANK</u> MIDDLE <u></u> LAST <u>Garcia</u>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <u>Ellen</u> MIDDLE <u></u> LAST <u>McDermott</u>  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>111-09-5322</u>  |  | 17 INFORMANT<br><u>Herman Singer husband</u>   |  | ADDRESS<br><u>Item # 13</u>  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIOSCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>  |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC ORGANIC BRAIN SYNDROME &amp; DIABETES</u>   |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN. 8</u> 19 <u>81</u> , to <u>APRIL 2</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>APRIL 2</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  | 22c. DATE SIGNED<br><u>4/2/81</u>            |  |
| 22b. SIGNATURE<br><u>R.C. Daddario</u>   |  | DEGREE<br><u>MD</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  |   |  |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ROBERT C. DADDARIO</u>   |  | 22f. ADDRESS<br><u>5413 CEDAR LANE BETHESDA</u>   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>Apr. 6, 1981</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Rockville, Montgomery, Md.</u>  |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Jos. Gawler's Sons</u>   |  |   |  | ADDRESS<br><u>5130 Wisc. Ave. Washington, D</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>CAPR 03 1981</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert C. Daddario</u> |  |  |  |

BP






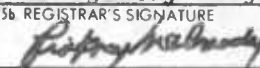
Franklin D. Roosevelt  
President of the United States  
Washington, D. C.  
Dear Mr. Roosevelt:  
I am very pleased to hear  
that you are well and hope  
you are enjoying your vacation.  
I am writing you to let you  
know that I am still in  
the hospital and am not  
able to return to work at  
this time. I am hoping to  
be discharged soon and  
return to my duties.

Very truly yours,  
[Signature]  
[Name]  
[Title]

Enclosed for you are  
two copies of the report  
of the committee on the  
subject of the proposed  
amendment to the  
constitution.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |  |   |  |  |  |   |  | REG. NO. 11034 |  |
|---|-------------------------|---|--|---|--|--|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ezra C. Smith</b>  |                         |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 4/30 19 81  |  | 2b. HOUR<br>3:10  |  |                |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 3, 1894</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>86 YRS.</b> | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 7c. DATE PRONOUNCED DEAD<br>4/30 19 81 | 24. HOUR<br>3:10   |  |   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                 |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>636 Falls Road</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Syburban Propane</b>  |  |                |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>636 Falls Road</b>  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Smith</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora Dove</b>   |  |  |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>443-05-7679</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Wayne M. Smith, 5108 Wilson Lane, Maryland Bethesda</b>  |  |  |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b><br><b>4291</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>  |                         |   |  |   |  |  |  |   |  |                |  |
| 19a. DATE OF OPERATION<br><b>None</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>None</b>  |  |  |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |  |  |   |  |                |  |
| ACTUAL SIGNATURE<br>   |                         | TITLE (SPECIFY)<br><b>Deputy</b> M.D.   |  |   |  | MEDICAL EXAMINER<br><b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>         |  |   |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John S. Rogers, M.D.</b>   |                         | ADDRESS<br><b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>   |  |   |  |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>May 4, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville Montgomery Maryland</b>   |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>   |                         |   |  | ADDRESS<br><b>Funeral Homes P/A 300 W. Montgomery Ave., Rockville, Md. 20850</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1981</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |                |  |



*[Faint, illegible handwritten text]*

MAY 1 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |  |  |  |                                    |  |  |  | 8 1 1 0 3 5  |  |                                   |  |                  |  |       |  |          |  |
|--|--|------------------------------|--|--|--|------------------------------------|--|--|--|--|--|-----------------------------------|--|------------------|--|-------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |                              |  | CERTIFICATE OF DEATH   |  |                                    |  |  |  | REG. NO.   |  |                                   |  |                  |  |       |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  | FIRST  |  | MIDDLE                             |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH                             |  | DAY              |  | YEAR  |  | 2b. HOUR |  |
| Frederick  |  |                              |  | Smith  |  |                                    |  |  |  | 4  |  | 7                                 |  | 8                |  | 1     |  | 9:30 AM  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |  |       |  |          |  |
| male   |  | Black                        |  | MONTH 1 DAY 14 YEAR 1893   |  |                                    |  | 87   |  |  |  | MONTHS                            |  | DAYS             |  | HOURS |  | MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                                   |  |                  |  |       |  |          |  |
| D.C.   |  | USA                          |  |  |  |                                    |  | Montgomery   |  |  |  |                                   |  |                  |  |       |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |  |       |  |          |  |
| Takoma PK  |  |                              |  | Washington Adventist Hosp.   |  |                                    |  | Retired  |  |  |  | None                              |  |                  |  |       |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  | 13b. CITY OR TOWN  |  |                                    |  | 13c. INSIDE CITY LIMITS?   |  |  |  | 13d. STREET ADDRESS               |  |                  |  |       |  |          |  |
| D.C.   |  |                              |  | Washington   |  |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |  |  | 4826 10th St. N.E.                |  |                  |  |       |  |          |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| UNKNOWN  |  |                              |  | Nettie Jackson   |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              |  | 16b. SOCIAL SECURITY NO.   |  |                                    |  | 17. INFORMANT  |  |  |  | ADDRESS                           |  |                  |  |       |  |          |  |
| NO   |  |                              |  | 577-09-8580-A  |  |                                    |  | Mr. Raymond F. Smith   |  |  |  |                                   |  |                  |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |                              |  |  |  |                                    |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                                   |  |                  |  |       |  |          |  |
| IMMEDIATE CAUSE (a) <u>Asphyxiation C.A. Tongues</u>   |  |                              |  |  |  |                                    |  |  |  | 2 hrs  |  |                                   |  |                  |  |       |  |          |  |
| 1419 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |                              |  |  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| DUE TO OR AS A CONSEQUENCE OF (b) <u>3rd physical C.A.?</u>  |  |                              |  |  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| DUE TO OR AS A CONSEQUENCE OF (c) <u>Trachea - 3rd physical Exhale</u>   |  |                              |  |  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| Edema  |  |                              |  |  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |                  |  |       |  |          |  |
| 3/26/81  |  |                              |  | Insufficient Feeding   |  |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                   |  |                  |  |       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF SHIPPED, NOTIFY MEDICAL EXAMINER)  |  |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                                   |  |                  |  |       |  |          |  |
|  |  |                              |  | P.M. 19  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |                                   |  |                  |  |       |  |          |  |
|  |  |                              |  |  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/15/81 to 4/5/81, that (he) (we) lost saw the deceased alive on 4/4/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |                              |  |  |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| 22b. SIGNATURE   |  |                              |  | DECEASEE   |  |                                    |  | ATTENDING PHYSICIAN  |  | MEDICAL DIRECTOR   |  | STAFF PHYSICIAN                   |  | 22c. DATE SIGNED |  |       |  |          |  |
| H.L. MARTER  |  |                              |  | 211 B  |  |                                    |  |  |  |  |  |                                   |  | 4/5/81           |  |       |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |  | 22e. ADDRESS   |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| H.L. MARTER  |  |                              |  | 831 University Blvd E.   |  |                                    |  |  |  |  |  |                                   |  |                  |  |       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |                                   |  |                  |  |       |  |          |  |
| BURIAL   |  |                              |  | 4-11-81  |  | GATE OF HEAVEN                     |  |  |  | WHEATON  |  | MD.                               |  |                  |  |       |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  |                              |  | 24b. ADDRESS   |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                                   |  |                  |  |       |  |          |  |
| John T. Rhines Co.   |  |                              |  | 3015 12th St. N.E., D.C.   |  |                                    |  | 200  |  | APR 15 1981  |  | R. J. [Signature]                 |  |                  |  |       |  |          |  |

RECEIVED



APR 15 1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR   |  |               |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH           |  |  |  |  |  |  |  |  |  | REG. NO. 11036     |  |
|--|--|---------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Marcia Goldberg Smith  |  |               |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 24 81 |  |  |  |  |  |  |  |  |  | 2b. HOUR 9:30 A.M. |  |
| 3. SEX Female  |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1946 34 YRS.   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.     |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD 4 24 81                           |  | 2d. HOUR 9:30 A.M.   |  |  |  |  |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. |  |  |  |  |  |  |  |                    |  |
| 10. CITY OR TOWN OF DEATH Bethesda   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10401 Grosvenor Lane |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY -----                    |  |  |  |  |  |  |  |                    |  |
| 13a. STATE Maryland  |  |               |  |  |  |  |  |  |  | 13b. COUNTY Montgomery   |  | 13c. CITY OR TOWN Rockville                                |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 10401 Grosvenor Lane |  |  |  |                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank ----- Goldberg   |  |               |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose ----- Heckelman                              |  |  |  |  |  |  |  |  |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |  |               |  | (IF YES, GIVE WAR OR DATES) -----  |  | 16b. SOCIAL SECURITY NO. 215-46-1602                       |  |  |  | 17. INFORMANT ADDRESS Rose Goldberg; 10401 Grosvenor Lane Rockville, Md.                     |  |  |  |  |  |  |  |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: 3485 Cerebral edema & uncatal herniation with midbrain compression<br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |               |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |  |  |                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| ACTUAL SIGNATURE   |  |               |  | TITLE (SPECIFY) Deputy Chief   |  |  |  | DATE SIGNED 4/25/81  |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |  |               |  | ADDRESS 111 Penn Street, Baltimore, MD. 21201  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE 4-26-81  |  | 23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Maryland                          |  |  |  |  |  |  |  |  |  |                    |  |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike  |  |               |  | ADDRESS Rockville, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR APR 28 1981  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                 |  |  |  |  |  |  |  |                    |  |

20% C13.04-613-617-1



Items #18a-22a Film G556 6/4/81  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

11037

|  |                             |   |   |   |
|--|-----------------------------|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MAYNA D. SMITH  |                             | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>4 14 19 81  |   | 2b. HOUR<br>M<br>2:45   |
| 3. SEX<br>female   | 4. RACE<br>white            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 16, 1882                  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>98 YRS.                 | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                         |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County  |                             | 10. CITY OR TOWN OF DEATH<br>Olney                                    |   |   |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital  |                             | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical  |
| 13a. STATE<br>Maryland   |                             | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Brookeville                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John David Dwyer   |                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sue Burton           |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                             | 16b. SOCIAL SECURITY NO.<br>220 46 5499                               |   | 17. INFORMANT<br>ADDRESS<br>Sandra Lee 7435 Takoma Park, MD<br>Baltimore Blvd.  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebro-vascular disease<br>8880<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |                             |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Cranio-cerebral trauma  |                             |   |   |   |
| 19a. DATE OF OPERATION   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 4/1/19 81   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject fell   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3730 Damascus Rd. Brookeville Montg. Md.   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |   |   |   |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.   |                             | TITLE (SPECIFY)<br>Assistant Medical Examiner                         |   | DATE SIGNED<br>4-15-81  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |                             | ADDRESS<br>111 Penn St. Baltimore, MD                                 |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>April 20, 1981 | 23c. NAME OF CEMETERY OR CREMATORY<br>Ivy Hill Cemetery               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Maryland |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Humphrey Funeral Homes P.A.  |                             | 25a. DATE REC'D. BY REGISTRAR<br>APR 23 1981                          |   | 25b. REGISTRAR'S SIGNATURE<br>R. A. Humphrey  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



*[Faint, mostly illegible text and markings covering the lower two-thirds of the page. Some words like "POSTAGE" and "PAID" are faintly visible. There are also some handwritten scribbles and lines.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

DHMH-16-30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                            |  |  |
|---|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DAVID P. SNELLINGS Sr.</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-27-81</b> |   | 2b. HOUR<br><b>7:50 PM</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-23-1884</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>97</b> YRS.                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Louisiana</b>                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Auditor</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>I.R.S.</b>                   |  |
| 13a. STATE<br><b>Md.</b>  |  |   |   | 13b. COUNTY<br><b>Pr. Geo.</b>  |                            | 13c. CITY OR TOWN<br><b>Hy.</b>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John P. Snellings</b>                        |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sara McCormick</b>  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>         |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-0427</b>  |   | 17. INFORMANT<br><b>808 Delafield St., NE Wash., D.C.</b>   |                            |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>pneumonia</b><br>(c) <b>arteriosclerotic heart disease</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b><br><b>24 hrs</b> |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) <del>Walter E. Goode</del> attended the deceased from <b>Jan 79</b> to <b>27 April 81</b> , that (I) <del>lost</del> saw the deceased alive on <b>27 April 19 81</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If I am not a physician, I did not view the body after death.) |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Walter E. Goode MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>28 April 81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER E. GOODE MD</b>   |  |  |  | 22e. ADDRESS<br><b>2309 SHOREFIELD RD WHEATON MD</b>   |  |  |  |

|  |  |                               |  |   |  |   |  |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                 |  | 23b. DATE<br><b>4-30-1981</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nalley's F.H. Inc. Mt. Rainier, Md.</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1981</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                            |  |



*[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Some words like "RECEIVED" and "JAN 19" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 8 1 1 0 3 9   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>Josephine M. Socha   |  | MONTH DAY YEAR<br>April 5 1981  |  |
| 3. SEX  |  | 2b. HOUR  |  |
| Female  |  | 1055 PM   |  |
| 4. RACE   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| White   |  | 62 YRS.   |  |
| 5. DATE OF BIRTH  |  | IF UNDER 1 YEAR   |  |
| MONTH DAY YEAR<br>9 7 18  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| U.S.A.  |  | Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |
| Wheaton   |  | Manor Care  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Secretary   |  | AFL-CIO   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13d. INSIDE CITY LIMITS?  |  |
| 13a. STATE CITY OR TOWN<br>MD. Mont. Rockville  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST<br>Samuel Maginello   |  | FIRST MIDDLE LAST<br>Marie Marianania   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| NO  |  | 192-01-5942   |  |
| 17. INFORMANT   |  | ADDRESS   |  |
| GARY T SOCHA  |  | SAME # 13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>1889 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 mos.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 6-11 1980 to 4/5 1981, that (I) (we) last saw the deceased alive on 4/5 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) touch the body after death.                 |  |   |  |
| 23a. SIGNATURE  |  | 23b. DATE SIGNED  |  |
| Myron L. Lenkin   |  | 4/5/81  |  |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 23d. ADDRESS  |  |
| MYRON L. LENKIN   |  | 2309 SHOREFIELD RD WHEATON, MD  |  |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23f. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | GATE OF HEAVEN CEM  |  |
| 23g. DATE   |  | 23h. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 4-8-81  |  | SILVER Spring MD  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25. DATE RECEIVED BY REGISTRAR  |  |
| Carmel D. Del   |  | APR 10 1981   |  |
| 26. ADDRESS   |  | 27. REGISTRAR'S SIGNATURE   |  |
| DE VOL FUNERAL HOME WHEELING  |  | Ruthy McBrady   |  |

BP

APR 10 1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 8 1 1 1 0 4 0  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.   |  |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>MAURICE</b>  |  |  | FIRST<br><b>SOLT</b>   |  |  | LAST<br><b>SOLT</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Apr. 12, 1981</b>                                       |  |  | 2b. HOUR P<br><b>5:10 M</b>                                |  |   |  |
| 3 SEX<br><b>MALE</b>  |  |  | 4 RACE<br><b>WHITE</b>   |  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>FEB. 4, 1904</b>  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>77</b>                 |  | 8 UNDER 24 HRS<br>HOURS MIN.<br><b>77</b> |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>                            |  |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>CHEVY CHASE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BETHESDA RETIREMENT CENTER</b> |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISOR</b>          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL SYS-TEM</b> |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>   |  |  | 13b COUNTY<br><b>MONT.</b>   |  |  | 13c CITY OR TOWN<br><b>KENSINGTON</b>  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e STREET ADDRESS<br><b>9612 Hawick Lane</b>              |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BARNET ZOLOTOROFF</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RACHEL METZ</b>   |  |  |  |  |  |  |  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b SOCIAL SECURITY NO.<br><b>104-20-3924A</b>   |  |  | 17 INFORMANT (Daughter)<br><b>AMY ANTONELLI</b>  |  |  | ADDRESS <b>9612 Hawick Lane Kensington, Maryland</b>   |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMA OF PROSTATE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MOS.</b>  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from <b>4/12</b> , 19 <b>81</b> , to <b>4/12</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not examine the body after death.                           |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>John J. Lynch</b>   |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  | 22c DATE SIGNED<br><b>4/12/81</b>  |  |  |  |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN J. LYNCH</b>  |  |  |  |  |  | 22e ADDRESS<br><b>10614 KING ST NW. WASH. DC 20010</b>   |  |  |  |  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  |  | 23b DATE<br><b>APR. 13, 81</b>   |  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b>   |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. Md.</b>                          |  |  |  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>DANZANSKY-GOLDBERG</b><br><b>MEMORIAL CHAPELS, INC.</b>  |  |  |  |  |  | ADDRESS <b>ROCKVILLE, MD.</b><br><b>1170 Rockville Pike</b>  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>APR 16 1981</b>   |  |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>            |  |   |  |





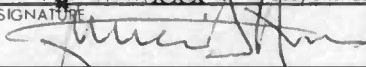
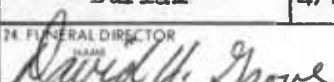

APR 18 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
 DHMH-16 30M 2/80  
 (VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  | 8   | 1 | 1  | 0 | 4   | 1 |
|---|--|---|--|---|--|--|--|--|--|---|---|--|---|---|---|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.  |   |  |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Evelyn Mae Spangler</b>   |  |   |  |   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 24, 1981</b>   |   |  |   | 2b. HOUR<br><b>6:25 a.m.</b>  |   |
| 2. SEX<br><b>Female</b>   |  | 3. RACE<br><b>White</b>                       |  | 4. DATE OF BIRTH MONTH DAY YEAR<br><b>May 16, 1913</b>  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | IF UNDER 24 HRS.                               |   |   |   |
| 5a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>   |  |   |   |  |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NIH, Clinical Center</b>                       |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |   |   |   |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Washington</b>  |  | 13c. CITY OR TOWN<br><b>Highfield</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>Box 42</b>  |   |  |   |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert E. Eyler Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bessie I. Flohr</b>  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>213-12-7553</b> |   | 17. INFORMANT ADDRESS<br><b>Barry E. Spangler Box 44 Highfield, Md.</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastatic Breast Cancer</b>   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>3 days</b><br><b>9 years</b>                                   |   |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |  |  |  |  |   |   |  |   |   |   |
| 19a. DATE OF OPERATION<br><b>None</b>   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |   |   |  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |   |  |   |   |   |
| 22a. I certify that <del>xx</del> (this hospital) attended the deceased from <b>March 27, 1981</b> to <b>April 24, 1981</b> , that <del>(I/we)</del> last saw the deceased alive on <b>April 24, 1981</b> , and that <del>xx</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I/we)</del> (did) <del>(do not)</del> view the body after death. |  |   |  |   |  |  |  |  |  |   |   |  |   |   |   |
| 22b. SIGNATURE<br>   |  |   |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/24/1981</b>  |   |  |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Barry E. Spangler</b>   |  |   |  |   |  |  |  | 22e. ADDRESS<br><b>NIH, Clinical Center Bethesda, Md.</b>  |  |   |   |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>4/26/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Cemetery</b>                   |  | 23d. LOCATION CITY OR TOWN<br><b>Lantz</b>   |  | COUNTY<br><b>Frederick</b>  |   | STATE<br><b>Md.</b>                            |   |   |   |
| 24. FUNERAL DIRECTOR<br>   |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br>                   |   |  |   |   |   |

24. FUNERAL DIRECTOR

ADDRESS

50 S. Broad St.  
Waynesboro, Pa.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

no.† = not dark

110

एडव-२८-ईस

January 2001

star of

27012

●

• **1991** : **1991**

24

1995/96

129

• 1000 •

• *crustacea*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 1 0 4 2  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME  |  |   |  | 2a. DATE OF DEATH  |  |  |  |
| (TYPE OR PRINT)   |  |   |  | MONTH DAY YEAR   |  |  |  |
| Grace H Sponsler  |  |   |  | 4 14 81  |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE   |  |
| F   |  | White   |  | MONTH DAY YEAR   |  | 83 YRS.  |  |
| October 22, 1897  |  |   |  |  |  |  |  |
| 7a. BIRTHPLACE  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| (STATE OR FOREIGN COUNTRY)  |  |   |  | NEVER MARRIED  |  | Mont. Co. MD.  |  |
| Harrisburg, Pa.   |  | United States   |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |   |  | (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |
| Bethesda  |  | Suburban Hospital                                       |  | Ret. Nurse-Mechanicsburg Hospital  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| 13a. STATE  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13b. COUNTY   |  |   |  | 13e. STREET ADDRESS  |  |  |  |
| Montgomery  |  |   |  | 401-Russell Avenue   |  |  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST  |  |  |  |
| Harry Weaver Hollinberger   |  |   |  | Naomi Nicholas   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |   |  | 17. INFORMANT  |  |  |  |
| (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  | er Rd., Bethesda, Maryland 20034   |  |  |  |
| No  |  |   |  | George Curtis Sponsler, III (Son) 7804-Old Chest   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  | 10 min   |  |  |  |
| IMMEDIATE CAUSE (a)   |  |   |  | Cardiac Arrest   |  |  |  |
| 4140  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  | (b) Arteriosclerotic Heart Disease   |  |  |  |
|   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
|   |  |   |  | (c)  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                |  |  |  |  |  |
|   |  | P.M. 19   |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-6-1981, to 4-14-1981, that (I) (we) lost   |  |   |  |  |  |  |  |
| saw the deceased alive on 4-13-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Stephen W. DeJeter, M.D.  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 4-14-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |  |  |
| STEPHEN W. DEJETER M.D.   |  |   |  | 6719 WILSON LANE, BETHESDA, MD 20834   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Cremation   |  | 4-14-1981   |  | Lee's Crematory  |  | CITY OR TOWN COUNTY STATE                                      |  |
|   |  |   |  |  |  | Washington, D.C.   |  |
| 24. FUNERAL DIRECTOR  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Gartner-Sandison F.H., Gaithersburg, MD 20760   |  |   |  | APR 20 1981  |  |  |  |

October 28, 1937

With

Harvard University, United States

Harvard Medical School

Harvard University, Cambridge, Massachusetts

Harvard Medical School

1937-1938

October 28, 1937

Harvard University, Cambridge, Massachusetts

Harvard Medical School, Cambridge, Massachusetts

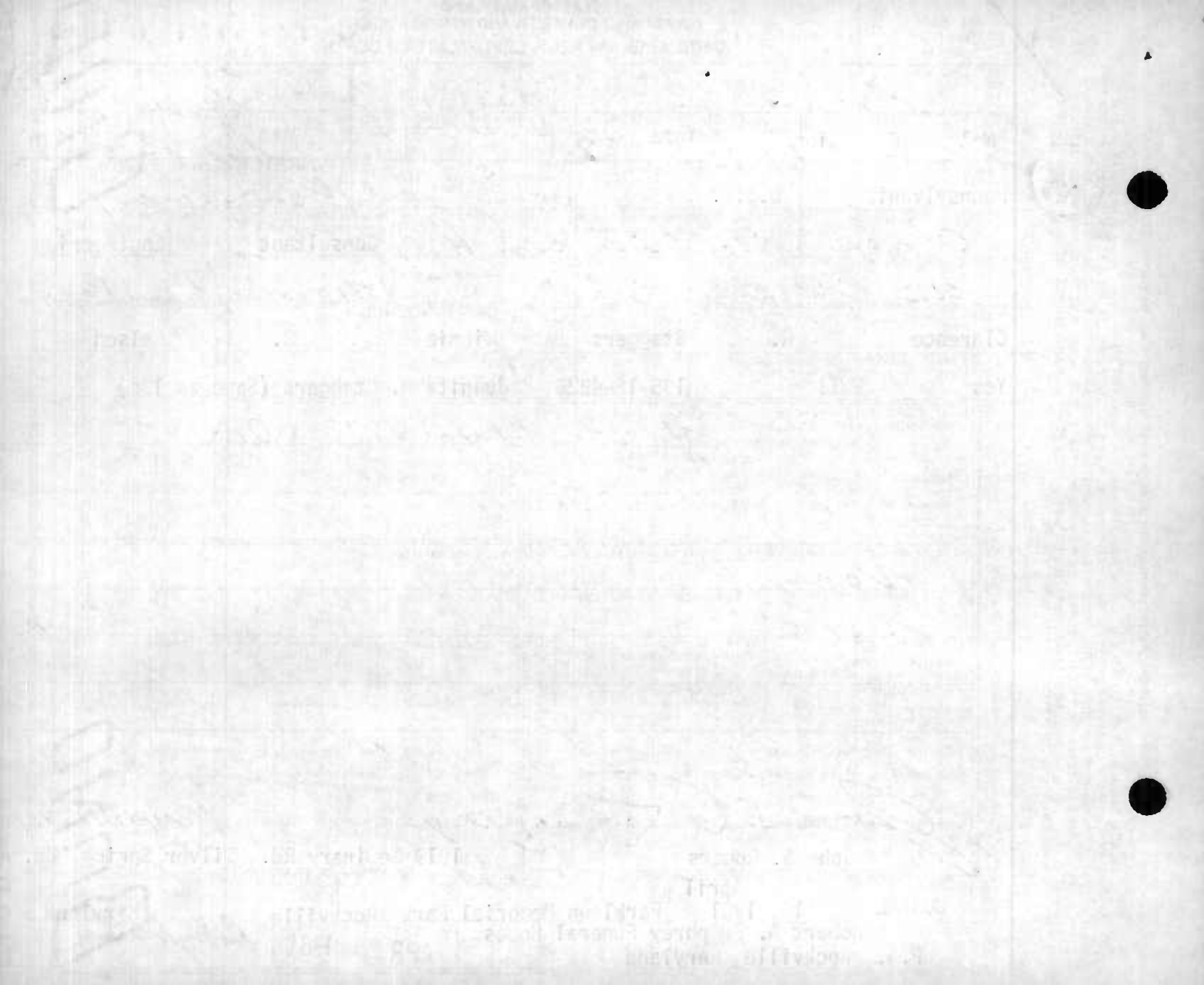
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                             |  |   |  |   |   |  |   | REG. NO. 11043  |  |
|--|--|-----------------------------|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Arthur B. Staggers</b>  |  |                             |  |   |  |   |   |  |   | 20. DATE KNOWN OF DEATH<br>MONTH DAY YEAR HOUR<br><b>April 14 1981 2 M</b>          |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 4, 1924</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>57 YRS.</b>  |   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br><b>57</b> |   | 21. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR HOUR<br><b>April 12 1981 11 M</b>        |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.           |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mont General Hosp</b> |   |  |   | 12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE)<br><b>Consultant</b>                           |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Engineering</b>                             |  |
| 13a. STATE<br><b>MD</b>  |  |                             | 13b. COUNTY<br><b>Monte</b>  |   | 13c. CITY OR TOWN<br><b>Rockville</b>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>13310 Turkey Branch Pkwy</b>                  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence R. Staggers</b>  |  |                             |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Winnie R. Nelson</b> |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>   |  |                             |  | 16b. SOCIAL SECURITY NO.<br><b>195-18-4226</b>              |  | 17. INFORMANT ADDRESS<br><b>Juanita M. Staggers (Same as 13e)</b>   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b><br><b>4291</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                             |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |  |                             |  |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>P.M. 19  |  |                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                             |  |   |  |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |  |                             |  |   |  | TITLE (SPECIFY)<br><b>Medical Examiner</b>  |   |  | DATE SIGNED<br><b>April 12 1981</b>                                     |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John S. Rogers</b>   |  |                             |  |   |  | ADDRESS<br><b>1919 Seminary Rd., Silver Spring, Md.</b>   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                             |  | 23b. DATE<br><b>April 15, 1981</b>                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland</b>   |  |                             |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 21 1981</b>   |   |  | 25b. NAME OF REGISTRAR<br><b>Deputy Registrar</b>                       |   |  |

BP

3302  
DHMH - 17  
FVR A15 ME (51)  
15M 7/76





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |   |   | 8 1 1 1 0 4 4  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CHERYL ANN STAUB   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 16, 1981                       |   | 2b. HOUR<br>1:00a M  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>October 20, 1968   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>12 YRS                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD            |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Clinical Center, Bethesda, MD NIH |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Pennsylvania  |   |   | 13b. CITY OR TOWN<br>New Oxford  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>RFD #1 17350  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Gordon D. Staub  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Charlotte M. Smith  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>181-60-5586   | 17. INFORMANT ADDRESS<br>Mrs Charlotte Staub (Mother - same)             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hemorrhagic shock<br>2040<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute lymphocytic leukemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from April 1, 1981, to April 16, 1981, that (X) (we) last saw the deceased alive on April 16, 1981, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22a. SIGNATURE DEGREE<br>Robert I. Parker M.D.  |   |   |  | 22b. DATE SIGNED<br>4/16/81   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert I. Parker   |   |   |  | 22b. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, MD 20205            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>4-18-81  | 23c. NAME OF CEMETERY OR CREMATORY<br>Union Cemetery                     |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>East Berlin Adams Pa.   |
| 24. FUNERAL DIRECTOR NAME<br>Hines / Rinaldi F.H. / 11800 New Hampshire Ave. Silver Spring, Md.   |   |   | 25a. DATED BY REGISTRAR<br>APR 20 1981                                   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ព្រះរាជក្រឹត្យ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

DHMM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |                   |   |  |
|--|-------------------|---|--|
| 1. FOR STATE REGISTRAR   |                   | REG. NO.  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) JACK H. STEIN  |                   | 2a. DATE OF DEATH MONTH DAY YEAR 4/28/81  |  |
| 3. SEX Male  |                   | 2b. HOUR 10 <sup>17</sup> A.M.  |  |
| 4. RACE WHITE  |                   | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 4 23 04  |                   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia   |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH Mont. County MD  |  |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT  |  |
| 10. CITY OR TOWN OF DEATH Silver Spring  |                   | 12b. KIND OF BUSINESS OR INDUSTRY GROCERY   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital   |                   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                   |   |  |
| 13a. STATE Md  | 13b. COUNTY Mont. | 13c. CITY OR TOWN Silver Spring   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH STEIN   |                   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELLA VERSUP   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |                   | 16b. SOCIAL SECURITY NO. 579-44-5627  |  |
| 17. INFORMANT BETTY STEIN  |                   | ADDRESS 1121 UNIVERSITY BOULEVARD, WEST SILVER SPRING, MARYLAND   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4241 Cerebral Anest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Valvular Disease                |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 24 h 6 years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hematoma - 1wk  |                   |   |  |
| 19a. DATE OF OPERATION   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/23/81 to 4/28/81, that (I) (we) lost the deceased alive on 4/28/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                   |   |  |
| 22b. SIGNATURE Ira Tublin  |                   | 22c. DATE SIGNED 4/28/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA TUBLIN, M.D.   |                   | 22e. ADDRESS 8830 CAMERON STREET, SILVER SPRING, MARYLAND   |  |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL   |                   | 23b. DATE 4/30/1981   |  |
| 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN FALLS CHURCH, VIRGINIA   |                   | 23d. LOCATION CITY OR TOWN  |  |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME  |                   | 25a. DATE REC'D. BY REGISTRAR MAY 4 1981  |  |
| 25b. REGISTRAR'S SIGNATURE   |                   |   |  |



5600 BP  
DHMH-16 50M 1-81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |   |   |   |  |
|--|--|---|---|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   |  | REG. NO.  |   |   |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Gregory Anthony STEPHENS, II</b>   |  |   |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16 1981</b>                          |   | 2b HOUR<br><b>1230A</b> M                               |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Negro</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 15 1981</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>11 11 55</b>               |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda,</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>       |   | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE 13b COUNTY 13c CITY OR TOWN<br><b>Maryland Pr. George Hyattsville</b>   |  |   |   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>1411 Kanawha St., Apt. 201</b> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gregory A. Stephens</b>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cheryl B. Stephens</b>          |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N/A</b>  |  | 16b SOCIAL SECURITY NO.<br><b>N/A</b>   |   | 17. INFORMANT ADDRESS<br><b>Cheryl B. Stephens See item 13</b>   |   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br><b>7651</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |  |   |   |   |   |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a I certify that (I/this hospital) attended the deceased from <b>Apr. 15</b> , 19 <b>81</b> , to <b>Apr. 16</b> , 19 <b>81</b> , that (I/(we) lost saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/(we) (did) (do) (do not) view the body after death.       |  |   |   |  |   |   |   |   |  |
| 22b SIGNATURE<br><b>Stanton K. Wesson</b> LTMCUSN<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |   |  |   | 22c DATE SIGNED<br><b>22 April 1981</b>   |   |   |  |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stanton K. Wesson, M.D.</b>   |  |   |   |  |   | 22f ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>                  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>5-6-1981</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Wm. Family Cemetery</b>  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Spottsylvania Va.</b>               |   | 25a. DATE BY REG. NO. 25b. REGISTRAR'S SIGNATURE<br><b>MAY 8 1981</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>W. W. Chambers Co.</b>   |  |   |   |  | ADDRESS<br><b>Silver Spring, Md.</b>  |   |   |   |  |

MEDICAL CERTIFICATION

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RUTH B. STICKLE</b>                     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 21, 1981</b>                         |  | 2b. HOUR<br><b>10:30 P M</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 23, 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>B. C.</b>                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>Gaithersburg</b>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>401 Russell Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Gaithersburg</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis E. Breuninger</b>              |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah I. Love</b>                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>577-09-5390</b>  |  | 17. INFORMANT ADDRESS<br><b>Germantown, Md.<br/>Harold J. Roach 14825 Spring Meadows Dr.</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4292**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) **Congestive Heart Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic Ischemic Cardiovascular Disease**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 12</b> , 19 <b>80</b> , to <b>Apr. 21</b> , 19 <b>81</b> , that <del>I</del> (we) last<br>saw the deceased alive on <b>Dec. 11</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, <del>I</del> (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Tibor E. Frekko MD</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>APR 22, 1981</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Tibor E. Frekko, M.D.</b>   |  | 22e. ADDRESS<br><b>19211 Mont. Village Ave. Gaith., Md. 20760</b>      |  |  |   |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>     | 23b. DATE<br><b>4/24/81</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b> |                             | 25. DATE RECEIVED BY REGISTRAR<br><b>MAY 4 1981</b>          |   |
| ADDRESS<br><b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>          |                             | 25b. REGISTRAR'S SIGNATURE                                   |   |



111

Dec. 11, 1901

To

"

"

"

"

"

"

"

"

"

Dec. 11, 1901

11

Dec. 11

80

Dec. 11

Dec. 11

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

| FOR<br>1- STATE REGISTRAR  |  |           |  |   |  |                   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                      |  |                |  |          |  |         |  | REG. NO.  |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|--|--|-----------|--|---|--|-------------------|--|--|--|--|--|--------------------------------------|--|----------------|--|----------|--|---------|--|---|--|----------------|--|----------|--|---------|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |           |  |   |  |                   |  |  |  | FIRST MIDDLE LAST  |  |                                      |  |                |  |          |  |         |  | 2a. DATE KNOWN OF ESTI-<br>MATED  |  | MONTH DAY YEAR |  | 2b. HOUR |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| ELMER L. STILL   |  |           |  |   |  |                   |  |  |  |  |  |                                      |  |                |  |          |  |         |  | 4   |  | 19             |  | 81       |  | 4:50 PM |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH DAY YEAR |  | 2d. HOUR |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| MALE   |  | CAUCASIAN |  | 12 29 17  |  | 63 YRS.           |  | MONTHS DAYS HOURS MIN.   |  |  |  | 4                                    |  | 19             |  | 81       |  | 4:50 PM |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |           |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                |  | MD.      |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| VERMONT  |  |           |  | U.S.A.  |  |                   |  |  |  |  |  | MONTGOMERY COUNTY                    |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| SILVER SPRING  |  |           |  | HOLY CROSS HOSPITAL - SIL. SPR.   |  |                   |  | BANK DIRECTOR  |  |  |  | PEACE CORP                           |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |           |  |   |  |                   |  |  |  | 13b. COUNTY  |  |                                      |  |                |  |          |  |         |  | 13c. CITY OR TOWN   |  |                |  |          |  |         |  |  |  | 13d. INSIDE CITY LIMITS?                                 |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS |  |  |  |  |  |  |  |  |  |
| MD.  |  |           |  |   |  |                   |  |  |  | MONTGOMERY   |  |                                      |  |                |  |          |  |         |  | SILVER SPRING   |  |                |  |          |  |         |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 11305 GILSAN STREET |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |           |  |   |  |                   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| ELMER  |  |           |  |   |  |                   |  |  |  | STILL  |  |                                      |  |                |  |          |  |         |  | GERTRUDE  |  |                |  |          |  |         |  |  |  | EATON  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |           |  |   |  |                   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |                                      |  |                |  |          |  |         |  | 17. INFORMANT   |  |                |  |          |  |         |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| NO   |  |           |  |   |  |                   |  |  |  | 009-05-8175  |  |                                      |  |                |  |          |  |         |  | BRENDA L. IGLESIAS  |  |                |  |          |  |         |  |  |  | SAME AS 13 DAUGHTER                                      |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |           |  |   |  |                   |  |  |  | PART I DEATH WAS CAUSED BY:  |  |                                      |  |                |  |          |  |         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 4291   |  |           |  |   |  |                   |  |  |  | IMMEDIATE CAUSE (a) Acute Myocardial Inf.  |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |           |  |   |  |                   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |           |  |   |  |                   |  |  |  | (b) Chronic Myocardial Dis.  |  |                                      |  |                |  |          |  |         |  | Yrs.  |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |           |  |   |  |                   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |           |  |   |  |                   |  |  |  | (c)  |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |           |  |   |  |                   |  |  |  | None   |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |           |  |   |  |                   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |  |                                      |  |                |  |          |  |         |  | 20. AUTOPSY?  |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| None   |  |           |  |   |  |                   |  |  |  |  |  |                                      |  |                |  |          |  |         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |           |  |   |  |                   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                       |  |                                      |  |                |  |          |  |         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |           |  |   |  |                   |  |  |  | P.M. 19  |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |           |  |   |  |                   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                        |  |                                      |  |                |  |          |  |         |  | 21f. LOCATION   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |           |  |   |  |                   |  |  |  |  |  |                                      |  |                |  |          |  |         |  | STREET CITY OR TOWN COUNTY STATE  |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |           |  |   |  |                   |  |  |  |  |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |           |  |   |  |                   |  |  |  | TITLE (SPECIFY)  |  |                                      |  |                |  |          |  |         |  | DATE SIGNED   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| JOHN S. ROGERS   |  |           |  |   |  |                   |  |  |  | M.D. Dep   |  |                                      |  |                |  |          |  |         |  | April 19, 1981  |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |           |  |   |  |                   |  |  |  | ADDRESS  |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| JOHN S. ROGERS   |  |           |  |   |  |                   |  |  |  | 1919 SEMINARY ROAD, SILVER SPRING, MD.   |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |           |  |   |  |                   |  |  |  | 23b. DATE  |  |                                      |  |                |  |          |  |         |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                |  |          |  |         |  |  |  | 23d. LOCATION  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| CREMATION  |  |           |  |   |  |                   |  |  |  | 4/20/81  |  |                                      |  |                |  |          |  |         |  | METROPOLITAN CREMATORY  |  |                |  |          |  |         |  |  |  | ALEXANDRIA VIRGINIA                                      |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |           |  |   |  |                   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                      |  |                |  |          |  |         |  | 25b. REGISTRAR'S SIGNATURE  |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| FRANCIS J. COLLINS   |  |           |  |   |  |                   |  |  |  | APR 28 1981  |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |           |  |   |  |                   |  |  |  |  |  |                                      |  |                |  |          |  |         |  |   |  |                |  |          |  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the Baltimore City Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE. This certificate must be filed with the death certificate in the Baltimore City Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   |  |  |   |  |   |  |
|---|--|---|---|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR <u>Marion D. Stull</u>   |  |   |   |  | REG. NO. <u>8111049</u>  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Stull, D. Marion</u>  |  |   |   |  | 2a. DATE OF DEATH MONTH <u>4</u> DAY <u>21</u> YEAR <u>1981</u>  |   |  | 2b. HOUR <u>1:30</u> P.M.   |  |
| 3. SEX <u>Female</u>  |  | 4. RACE <u>Cauc</u>   |   | 5. DATE OF BIRTH MONTH <u>2</u> DAY <u>27</u> YEAR <u>89</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> <u>92</u> YRS.                            |  | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Frederick, MD</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD                           |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>Olney, MD</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SHARON NURSING Home</u> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Cook in School</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |   |  |   |  |
| 13a. STATE <u>MD</u>  |  | 13b. COUNTY <u>Fred.</u>  |   | 13c. CITY OR TOWN <u>Frederick</u>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <u>Rt 1, Thurmont, MD</u>   |  |
| 14. FATHER'S NAME FIRST <u>Edward</u> MIDDLE <u>M.</u> LAST <u>Webster</u>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>Elizabeth</u> LAST <u>Gonst</u>   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Unknown</u>  |  |   | 16b. SOCIAL SECURITY NO. <u>214-34-2218</u>                         |  | 17. INFORMANT ADDRESS <u>Carol Whiting RN</u>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4850 Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>13000 Bronchial Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hours</u><br><u>16 days</u>                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Senile Dementia</u>   |  |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>         |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                      |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1978</u> to <u>April 21, 1981</u> , that (I) (we) lost the deceased alive on <u>April 19, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE <u>Carol Whiting MD</u>  |  |   |   |  | DEGREE   |   | 22c. DATE SIGNED <u>April 21, 1981</u> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Albert S Whiting</u>   |  |   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   |  |
| 22e. ADDRESS <u>3933 Rockwell Dr Laurel MD</u>  |  |   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>   |  |   | 23b. DATE <u>4/24/81</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Utica Cemetery</u>   |   | 23d. LOCATION <u>Utica Fred. Md.</u>   |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Stanffer Funeral Home</u> ADDRESS <u>4/21/81</u>   |  |   |   |  | 25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE   |   |  |   |  |

to be given to WHS. Morse. 4/23/81  
Ratner  
Stanffer

4/25/81  
Burial  
Police  
Fred. M.

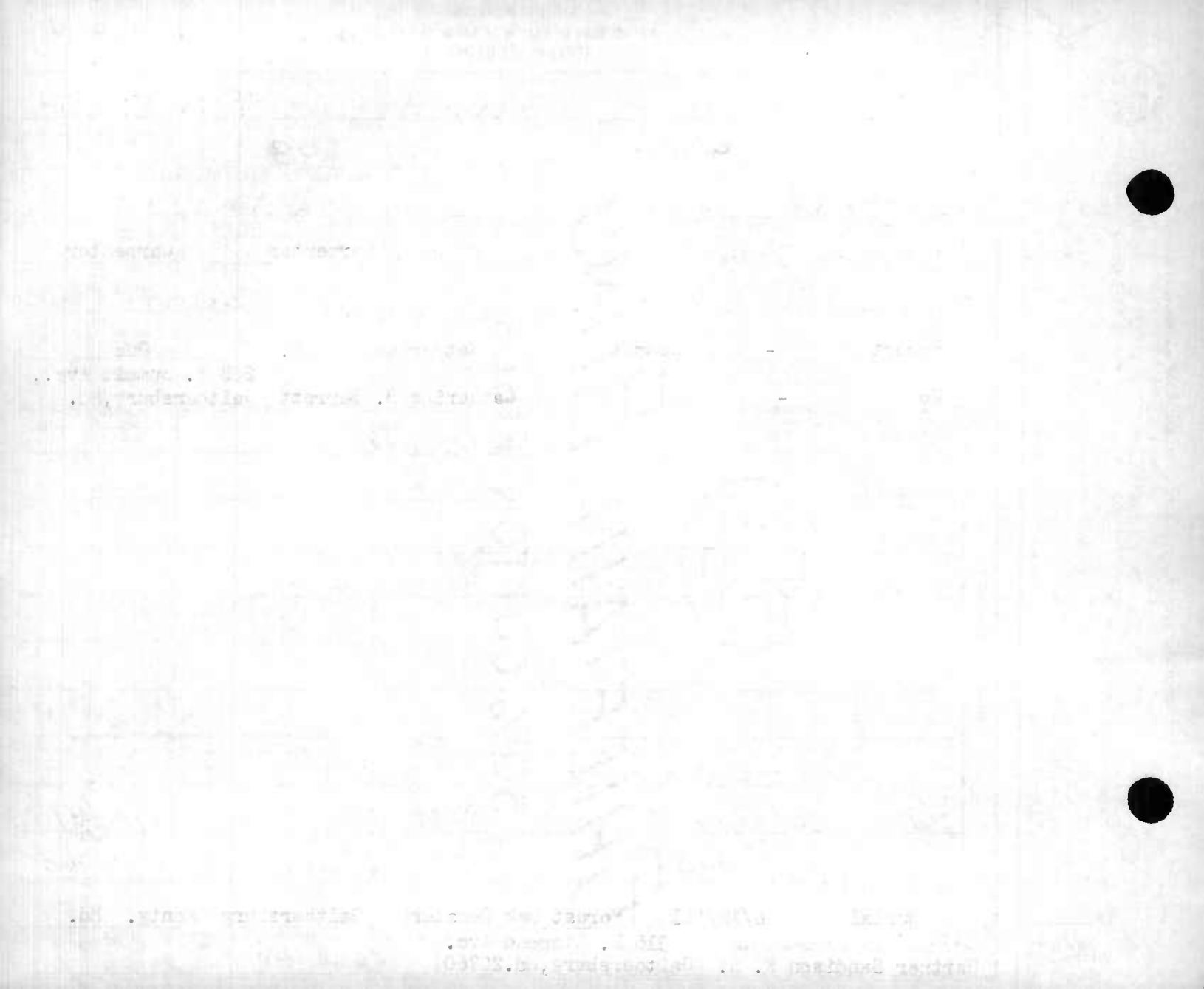


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |  | 8 1 1 1 0 5 0 |  |  |  |
|---|--|---|--|---|--|---|--|--|--|---------------|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | REG. NO.      |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EDGAR M. SUDDATH</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 16 81</b>  |  | 2b. HOUR<br><b>0330A</b>                                   |  |               |  |  |  |
| 3. SEX<br><b>m</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 27 87</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>93</b>   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |               |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |  |  |               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Advent. Hosp</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Carpenter</b>      |  |               |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  |   |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Gaithersburg</b>                   |  |               |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert - Suddath</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Katherine M. One</b>   |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-325-488</b>  |  | 17. INFORMANT ADDRESS<br><b>208 N. Summit Ave., Gaithersburg, Md.</b>   |  |   |  |  |  |               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized debility</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dehydration, septicemia, extensive decubiti</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3d</b><br><b>6m</b> |  |   |  |   |  |   |  |  |  |               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |  |  |  |               |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |               |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>3/13</b> , 19 <b>81</b> , to <b>4/16</b> , 19 <b>81</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>4/15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |  |   |  |  |  |               |  |  |  |
| 22b. SIGNATURE<br><b>Robert Millman, MD</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/15/81</b>  |  |  |  |               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Millman, MD</b>  |  | 22e. ADDRESS<br><b>15 Deer Park Dr Gaithersburg Md 20860</b>  |  |   |  |   |  |  |  |               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/18/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Oak Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Gaithersburg Montg. Md.</b>   |  |  |  |               |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Gartner Sandison F. H.</b>   |  | 316 E. Diamond Ave.<br><b>Gaithersburg, Md. 20760</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |               |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |   |  |  |
|---|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Richard M. Sweeney</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1981</b>                            |   |  | 2b. HOUR<br><b>2:37A. M</b>  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 13, 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maine</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                            |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Administrator</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Rockville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>11600 Split Rail Court</b>  |  |   |   |   |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter James Sweeney</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Francis Miller</b>                  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>                  |   | 17. INFORMANT<br>ADDRESS<br><b>Jean M. Sweeney (Same as 13e)</b>               |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4254</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic respiratory failure: ?ETHIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1hr</b><br><b>2yrs</b><br><b>5yrs.</b> |  |   |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>none</b>  |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>May 20</b> |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>April 16 81</b>               |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 13 1981</b> to <b>April 16 1981</b> , that (I) (we) last saw the deceased alive on <b>April 13 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Kirk E. Flury M.D.</b>   |  |   | DEGREE  |   |  | 22c. DATE SIGNED<br><b>4/16/81</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KIRKE FLURY M.D.</b>  |  |   | 22e. ADDRESS<br><b>9410 Old Georgetown</b>  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>April 20, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville Maryland</b>                  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 24 1981</b>                                     |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>                                  |   |  |  |
| P.A. Bethesda, Maryland   |  |   |   |   |  |  |   |  |  |

RECEIVED 13 1962

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

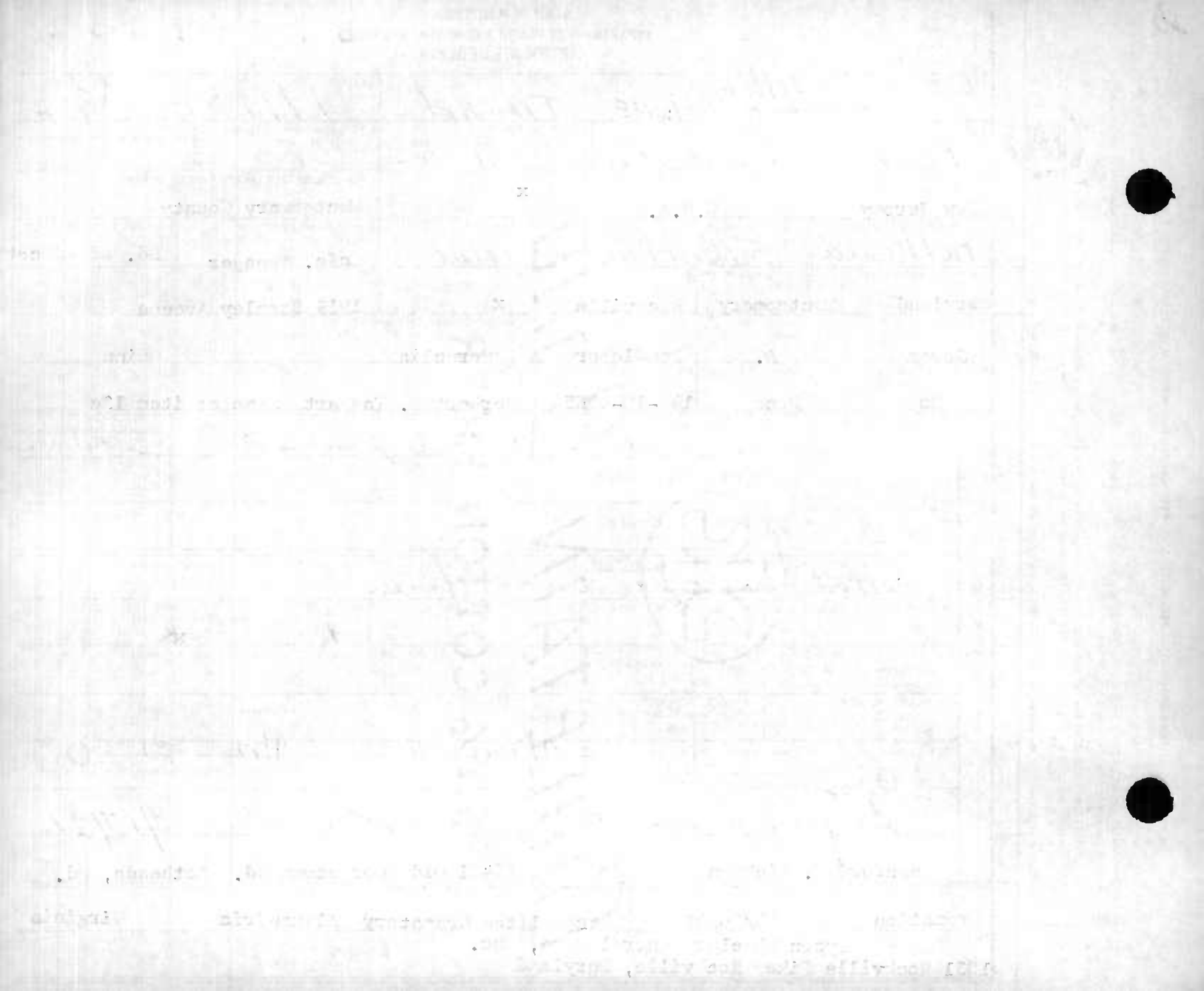
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |   |  | 8 1 1 1 0 5 2 |  |
|--|--|---|--|---|--|--|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |   |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Lillian Anne Taggart</i>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>4/17/81</i>                     |  |  | 2b. HOUR<br><i>9 A.M.</i>   |  |               |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>Caucasian</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>10 11 22</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>58</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>New Jersey</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County</i> MD.                     |  |   |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sieburth Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Cafe, Manager</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Bd. of Educat.</i>  |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i>  |  |   |  |   | 13b. COUNTY<br><i>Montgomery</i>                                       |  | 13c. CITY OR TOWN<br><i>Rockville</i>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James A. Pendlebury</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Cornelia Quinn</i> |  |  |   |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <i>None</i>    |   | 17. INFORMANT<br>ADDRESS<br><i>Herbert H. Taggart Same as item 13c</i> |  |  |   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute hemorrhagic pancreatitis</i><br><i>5770</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several weeks</i> |  |   |  |   |  |  |  |   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>asthma, bronchitis, acute renal failure</i>  |  |   |  |   |  |  |  |   |  |               |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |  |   |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/15</i> , 19 <i>81</i> , to <i>4/17</i> , 19 <i>81</i> , that (I) (we) lost <i>slowly</i> the deceased, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did) not view the body after death.  |  |   |  |   |  |  |  |   |  |               |  |
| 22b. SIGNATURE<br><i>Sanford N. Richman, M.D.</i>  |  |   |  |   | DEGREE   |  | 22c. DATE SIGNED<br><i>4/17/81</i>                                       |   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Sanford N. Richman</i>   |  |   |  |   | 22e. ADDRESS<br><i>10401 Old Georgetown Rd. Bethesda, Md.</i>          |  |  |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>   |  |   | 23b. DATE<br><i>4/20/81</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Metropolitan Crematory</i>    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Alexandria Virginia</i> |   |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Tyson Wheeler Funeral Home, Inc.<br/>1331 Rockville Pike Rockville, Maryland</i>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 22 1981</i>                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey McCreedy</i>                    |   |  |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | REG. NO. 11053  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY M. TERCERO</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>4 4 81</b>  |  | 2b. HOUR <b>4:59am</b>  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 12 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Interpreter</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>State Dept.</b>  |  |
| 13a. STATE <b>D.C.</b>  |  | 13b. COUNTY <b>Washington</b>   |  | 13c. CITY OR TOWN <b>Washington</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles McNutt</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Stroup</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>579-44-7541</b>   |  | 17. INFORMANT ADDRESS <b>Joseph K. Tercero Son. 303 Silver Spring, Md 20904</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bilateral Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Obstructive Lung Disease</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>48 hrs</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/2/81</b> 19 <b>81</b> , to <b>4/4/81</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Paul W. Johnson</b> MD  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>4/4/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul W. Johnson</b>  |  |   |  | 22e. ADDRESS <b>6111 Executive Blvd., Rockville, Md. 20852</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>4/7/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> NAME <b>5130 Wisc. Ave., N.W. Wash., D.C.</b> ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 08 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Robert Hebrud</b>   |  |

CONFIDENTIAL

78

1944

XX

U.S.A.

1944

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL



CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 1 1 0 5 4   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BARBARA HARTWELL THOMAS</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>APRIL 03 1981</b>  |  | 2b. HOUR<br><b>4:40 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 13 1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS MIN.<br><b>56</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON DC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Ctr.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN<br><b>WHEATON</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br><b>HAROLD WEST JOHNSON</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br><b>LOUISE FERGUSON</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>567-26-5028</b>   |  | 17. INFORMANT ADDRESS<br><b>JESSE F. THOMAS, Same as 13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA, METASTATIC</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>15 MAR 19 81</b> to <b>03 APR 19 81</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) (did) (not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Gary J. Sladek MD</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/7/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G.G. SLADECK LCDR/MC/USNR</b>  |  |  |  | 22e. ADDRESS<br><b>NNMC BETHESDA, MD</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 7, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>  |  | 23d. LOCATION CITY COUNTY STATE<br><b>Arlington, Virginia</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 03 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |



100000

100000

100000

100000



100000

100000

100000

100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 1 0 5 5  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELOISE J Thomas</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-2-81</b>   |  | 2b. HOUR<br><b>9:08 AM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 12, 1922</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>D.C.</b>   |   | 13b. CITY OR TOWN<br><b>Washington</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5417 Central Ave., S.E.</b>                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Peoples</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie Rembert</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>114-16-7830</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Cleotha Thomas-Same as # 13 above</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4310 Intracerebral Hematoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac and Respiratory</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/30</b> , 19 <b>81</b> , to <b>4/2</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/2</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |   |   |   |  |  |
| 22b. SIGNATURE<br><b>William W. Briehts</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>4-3-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William W. Briehts</b>  |   | 22e. ADDRESS<br><b>2141 K St. N.W. DC</b>   |   |  |  |
| 23. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE<br><b>4-7-81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HARMONY MEM. PARK</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HIGHLAND PARK P.G. MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H.S. WASHINGTON + Sons</b>   |   | ADDRESS<br><b>4925 Burkwoods Ave. N.E.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1981</b>                                  |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lester Kelly</b>                                    |  |

BP



WILLIAM  
2080

APR 10 1981

*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 1 0 5 6  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>George M. Thomas  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-28-81   |  |
| 3. SEX<br>Male  |  | 2b. HOUR<br>7:25 PM   |  |
| 4. RACE<br>White  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>9 26 30  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>DISTRICT OF Columbia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma PK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASH ADV HOSP               |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>NIH  |  |
| 13a. STATE<br>Md.   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 13c. COUNTY<br>Howard   |  | 13d. STREET ADDRESS<br>10706 Judy Lane  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Thomas  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen Steers  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>579 36 6337   |  |
| 17. INFORMANT<br>Mary Thomas (Wife)   |  | ADDRESS<br>same as above  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>7101<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Fibrosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Progressive Systemic Sclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 years<br>7 years |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1978</u> to <u>APRIL 28</u> 19 <u>81</u> , that (I) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <u>APRIL 28</u> 19 <u>81</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.   |  |   |  |
| 22b. SIGNATURE<br>Norton Elson  |  | 22c. DATE SIGNED<br>4/29/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NORTON ELSON   |  | 22e. ADDRESS<br>6525 Belcrest Road Hyattsville  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5/1/81   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery Brentwood PG Md.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi F.H.11800 N.H.Ave. S.S.Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 4 1981   |  |
| 25b. REGISTRAR'S SIGNATURE  |  |   |  |

12-25-1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 8 1 1 1 0 5 7<br>CERTIFICATE OF DEATH                         |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 20. DATE OF DEATH   |  |  |  |  |
| JAMES NMI THOMAS   |  |  |  |  | APRIL 04 1981   |  |  |  |  |
| 3. SEX   |  |  |  |  | 21. DATE OF DEATH   |  |  |  |  |
| MALE   |  |  |  |  | 21. DATE OF DEATH   |  |  |  |  |
| 4. RACE  |  |  |  |  | 22. HOUR  |  |  |  |  |
| NEGROID  |  |  |  |  | 2015PM  |  |  |  |  |
| 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |  |  |  |
| AUG 27 1925  |  |  |  |  | 55 YRS.   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |  |  |
| NEW YORK   |  |  |  |  | MONTGOMERY MD.  |  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |  |  |
| U.S.A.   |  |  |  |  | CAPITOL POLICE  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |  |  |  |
| BETHESDA   |  |  |  |  | NONE  |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  |  | 13a. STREET ADDRESS   |  |  |  |  |
| NATIONAL NAVAL MED. CENTER   |  |  |  |  | 2709 FINCH ST.  |  |  |  |  |
| 13a. STATE   |  |  |  |  | 13b. CITY OR TOWN   |  |  |  |  |
| MD   |  |  |  |  | SILVER SPRING   |  |  |  |  |
| 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS?                                      |  |  |  |  |
| MONTGOMERY   |  |  |  |  | YES X NO  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |  |  |  |
| JOHN NMI THOMAS  |  |  |  |  | DELIA NMI UNKNOWN   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.                                      |  |  |  |  |
| YES  |  |  |  |  | 1948-1970 125160539   |  |  |  |  |
| 17. INFORMANT  |  |  |  |  | ADDRESS   |  |  |  |  |
| SHIRLEY THOMAS   |  |  |  |  | 2709 FINCH ST.  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |  |  |  |
| IMMEDIATE CAUSE (a) Carcinoma of pancreas  |  |  |  |  |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |   |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |   |  |  |  |  |
| 20a. AUTOPSY?  |  |  |  |  |   |  |  |  |  |
| YES NO   |  |  |  |  |   |  |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |   |  |  |  |  |
| YES NO   |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |   |  |  |  |  |
| 21b. TIME OF INJURY  |  |  |  |  |   |  |  |  |  |
| HOUR A.M. MONTH DAY YEAR   |  |  |  |  |   |  |  |  |  |
| P.M. 19  |  |  |  |  |   |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  |   |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |   |  |  |  |  |
| 21f. LOCATION  |  |  |  |  |   |  |  |  |  |
| STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from MARCH 30 19 81, to APRIL 04 19 81, that (X) (we) lost saw the deceased alive on APRIL 04 19 81, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |   |  |  |  |  |
| GARY SLADEK MD   |  |  |  |  |   |  |  |  |  |
| 22c. DATE SIGNED   |  |  |  |  |   |  |  |  |  |
| APR. 6, 1981   |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |   |  |  |  |  |
| GARY SLADEK, M.D.  |  |  |  |  |   |  |  |  |  |
| 22e. ADDRESS   |  |  |  |  |   |  |  |  |  |
| NATIONAL NAVAL MED CEN, BETHESDA, MD   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  |  |  |   |  |  |  |  |
| BURIAL   |  |  |  |  |   |  |  |  |  |
| 23b. DATE  |  |  |  |  |   |  |  |  |  |
| 4-10-81  |  |  |  |  |   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |   |  |  |  |  |
| ARLINGTON NATIONAL   |  |  |  |  |   |  |  |  |  |
| 23d. LOCATION  |  |  |  |  |   |  |  |  |  |
| CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |  |  |  |
| ARLINGTON ARLINGTON VA   |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |   |  |  |  |  |
| JOHN T. RHINES FUNERAL HOME WASHINGTON, D.C.   |  |  |  |  |   |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR  |  |  |  |  |   |  |  |  |  |
| APR 15 1981  |  |  |  |  |   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |   |  |  |  |  |
| [Signature]  |  |  |  |  |   |  |  |  |  |

*Handwritten signature*

APR 15 1981

COLORED FILMS

*Vertical handwritten text, possibly "Kodak"*





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE   |  |
| Charles Thornton   |  | Male  |  | Blk.  |  |
| 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |
| Feb. 27 1933   |  | 48  |  | W. Virginia   |  |
| 8. CITIZEN OF WHAT COUNTRY?  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. CITY OR TOWN OF DEATH   |  |
| U.S.A.   |  | Mont.   |  | Takoma Park   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Washington Adventist Hospital  |  | Janitor   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| Md.  |  | Takoma Park   |  |   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                        |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |
| Luther Thornton  |  | Hazel M. Washington   |  | Yes   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  |
| 233-50-1347  |  | Hazel M. Thornton-401 K St., N.W. D.C.                              |  | CARDIO - RBSO ARREST<br>4290<br>Congestive Heart Failure<br>Myocarditis, chronic<br>Diabetes, Cholelithiasis, Hypertension  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 19c. ALLOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 5-21-80 to 4-28-81, that (1) (we) lost saw the deceased alive on 2-16-81, and that (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death. |  | 22b. SIGNATURE (DEGREE) John L. Ford M.D.                           |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN L. FORD  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 5-4-81  |  | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Md.  |  | 24. FUNERAL DIRECTOR NAME Robt. G. Mason Funeral Home               |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 1 - 1981  |  |

Robert G. Mason Funeral Home 1661 Good Hope Rd. S.W.  
 2-1-81  
 Charleston, W.V.

Yes 1952-1959 233-50-1317 Daniel M. Thornton-101 K St., N.W., D.C.

Father Thornton Daniel

Md. Lakona Park X Yvon Marie Es.

Lakona Park Washington, D.C. Lakona

W. Virginia U.S.A. X

Male 27 1933 18

Christine Thornton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |   |  | 8  | 1 | 1   | 0 | 5  | 9 |
|--|--|--|--|--|--|---|--|---|--|--|---|---|---|--|---|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |   |  |   |  | REG. NO.   |   |   |   |  |   |
| 1 DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> JOSEPH <sup>MIDDLE</sup> CAPERTON <sup>LAST</sup> TINGLER   |  |  |  |  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>APRIL 23 81 6:10 AM                             |   |   |   |  |   |
| 3 SEX Male   |  | 4 RACE white   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>July 22, 1906                                |  | 6 AGE (IN YEARS LAST BIRTHDAY) 74   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. |   |
| 10 CITY OR TOWN OF DEATH Kensington  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner          |  | 12b. KIND OF BUSINESS OR INDUSTRY Mining  |  |  |   |   |   |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Mont. 13c. CITY OR TOWN Olney   |  |  |  |  |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS 4113 Charley Forest St.   |   |  |   |
| 14 FATHER'S NAME <sup>FIRST</sup> Frank <sup>MIDDLE</sup> - <sup>LAST</sup> Tingler  |  |  |  |  | 15 MOTHER'S MAIDEN NAME <sup>FIRST</sup> Willie <sup>MIDDLE</sup> - <sup>LAST</sup> Bunion |   |  |   |  |  |   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO. 236-10-7581-A   |  | 17 INFORMANT Lillian Tingler   |  | ADDRESS Same as #13   |  |   |  |  |   |   |   |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>1629 IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |   |  |  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |  |   |   |   |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |   |  |  |   |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 19 81 to 4/22 19 81, that (I) (we) last saw the deceased alive on March 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |   |  |  |   |   |   |  |   |
| 22b. SIGNATURE Raymond Bass  |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED 4/23/81  |  |  |   |   |   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS   |  |  |  | 22e. ADDRESS 10620 Georgia Ave Silver Spring Md.                               |  |   |  |   |  |  |   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL REMOVAL-(Burial)   |  | 23b. DATE Apr. 24, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY Fayetteville Cemetery                       |  | 23d. LOCATION Fayetteville  |  | COUNTY Fayette  |  | STATE W.Va.  |   |   |   |  |   |
| 24 FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20760  |  |  |  | 25a. DATE REC'D. BY REGISTRAR APR 27 1981                                      |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |   |   |   |  |   |

APR 12 1944

THURSDAY

APR 12 1944



41

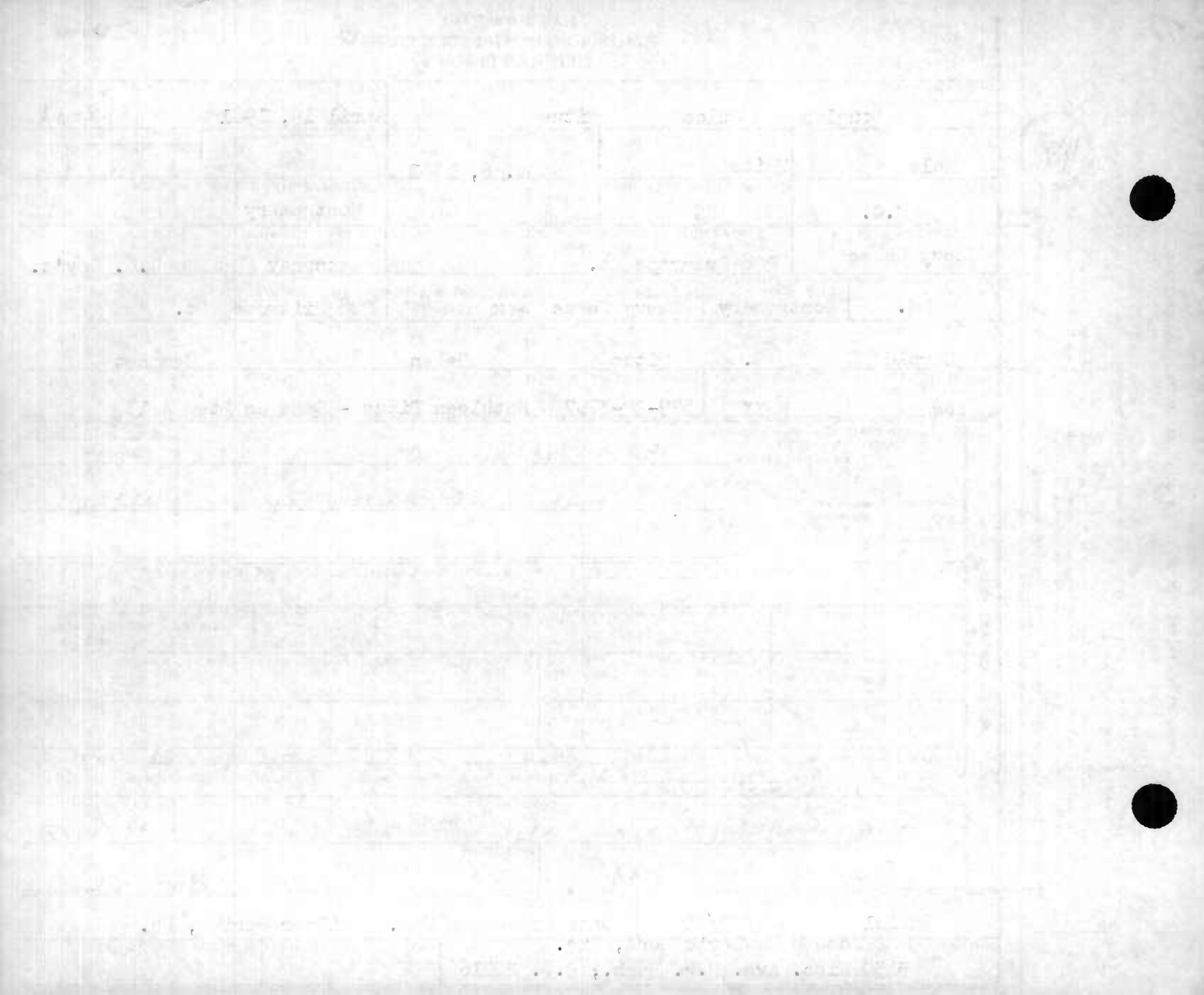
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                                    |   |  | 8 1 1 1 0 6 0  |  |
|---|------------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR  |                                    |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Douglas Jules Titus   |                                    |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 19, 1981          |  | 2b. HOUR<br>8:01 AM  |
| 3. SEX<br>Male  | 4. RACE<br>White                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 6, 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>D.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase  |                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>208 Primrose St.                               |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attorney         | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.   |
| 13a. STATE<br>Md.   |                                    |   | 13b. COUNTY<br>Montgomery                                      | 13c. CITY OR TOWN<br>Chevy Chase   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harold H. Titus   |                                    |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Demonet |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |                                    | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 579-20-3797   |  | 17. INFORMANT<br>Kathleen Titus - Same as Item # 13                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cer Pulmonary</u><br>4920 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |                                    |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs<br>10 yrs  |
| 19a. DATE OF OPERATION  |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>79</u> , to <u>April 19</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>April 18</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                                    |   |  |  |  |
| 22b. SIGNATURE<br><u>John Radeliff H. Ewan</u>  |                                    | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>4/19/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN R EWAN  |                                    | 22e. ADDRESS<br>916 - 19 ST NW WASH. DC   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                                    | 23b. DATE<br>4/22/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate Of Heaven Cem.                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Md.  |                                    | 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.<br>NAME 5130 Wisc. Ave. N.W. Wash., D.C. 20016 ADDRESS  |  |  |  |
| 25a. DATE RECD. BY REGISTRAR<br>APR 24 1981   |                                    |   |  | 25b. REGISTRAR'S SIGNATURE   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DULILIO E. TOROBO  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 29 81                        |   |  | 2b. HOUR<br>12 05 AM  |  |  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 3 1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CUBA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>CUBA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PRINTER   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |   |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>MONTGOMERY   |   | 13c. CITY OR TOWN<br>TAKOMA PARK  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br>8713 GILBERT PLACE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MANUEL TOROBO   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CARLOTA RECALDE  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-76-7368   |   | 17. INFORMANT<br>ADDRESS<br>ORLANDO J. TOROBO SAME AS 13 SON  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency</i><br>7 4810<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>Isolated lobar pneumonia</i><br>(c) <i>Due to, or as a consequence of</i> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital), attended the deceased from <i>04/28/81</i> 19, to <i>04/29/81</i> 19, that (I) (we) lost saw the deceased alive on <i>04/28/81</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Miguel A. Rodriguez</i><br>DEGREE  |  |   |   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIGUEL A. RODRIGUEZ  |  |   |   | 22e. ADDRESS<br>8634 Flower Ave, T. Park Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>5/1/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME FRANCIS J. COLLINS<br>500 UNIVERSITY BLVD., W., SILVER SPRING, MD.   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 4 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>  |  |  |  |



NOTES FOR  
M. J. H. H. D.

1. The first part of the report is a general description of the project and its objectives. It is followed by a detailed description of the methodology used in the study. The results of the study are then presented in a series of tables and figures. The final part of the report is a discussion of the results and their implications for future research.

2. The second part of the report is a detailed description of the methodology used in the study. It includes a description of the data sources, the data collection process, and the data analysis techniques used. The results of the study are then presented in a series of tables and figures. The final part of the report is a discussion of the results and their implications for future research.

3. The third part of the report is a detailed description of the methodology used in the study. It includes a description of the data sources, the data collection process, and the data analysis techniques used. The results of the study are then presented in a series of tables and figures. The final part of the report is a discussion of the results and their implications for future research.

4. The fourth part of the report is a detailed description of the methodology used in the study. It includes a description of the data sources, the data collection process, and the data analysis techniques used. The results of the study are then presented in a series of tables and figures. The final part of the report is a discussion of the results and their implications for future research.

5. The fifth part of the report is a detailed description of the methodology used in the study. It includes a description of the data sources, the data collection process, and the data analysis techniques used. The results of the study are then presented in a series of tables and figures. The final part of the report is a discussion of the results and their implications for future research.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M  
(VRA 15, 4) 1/791- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

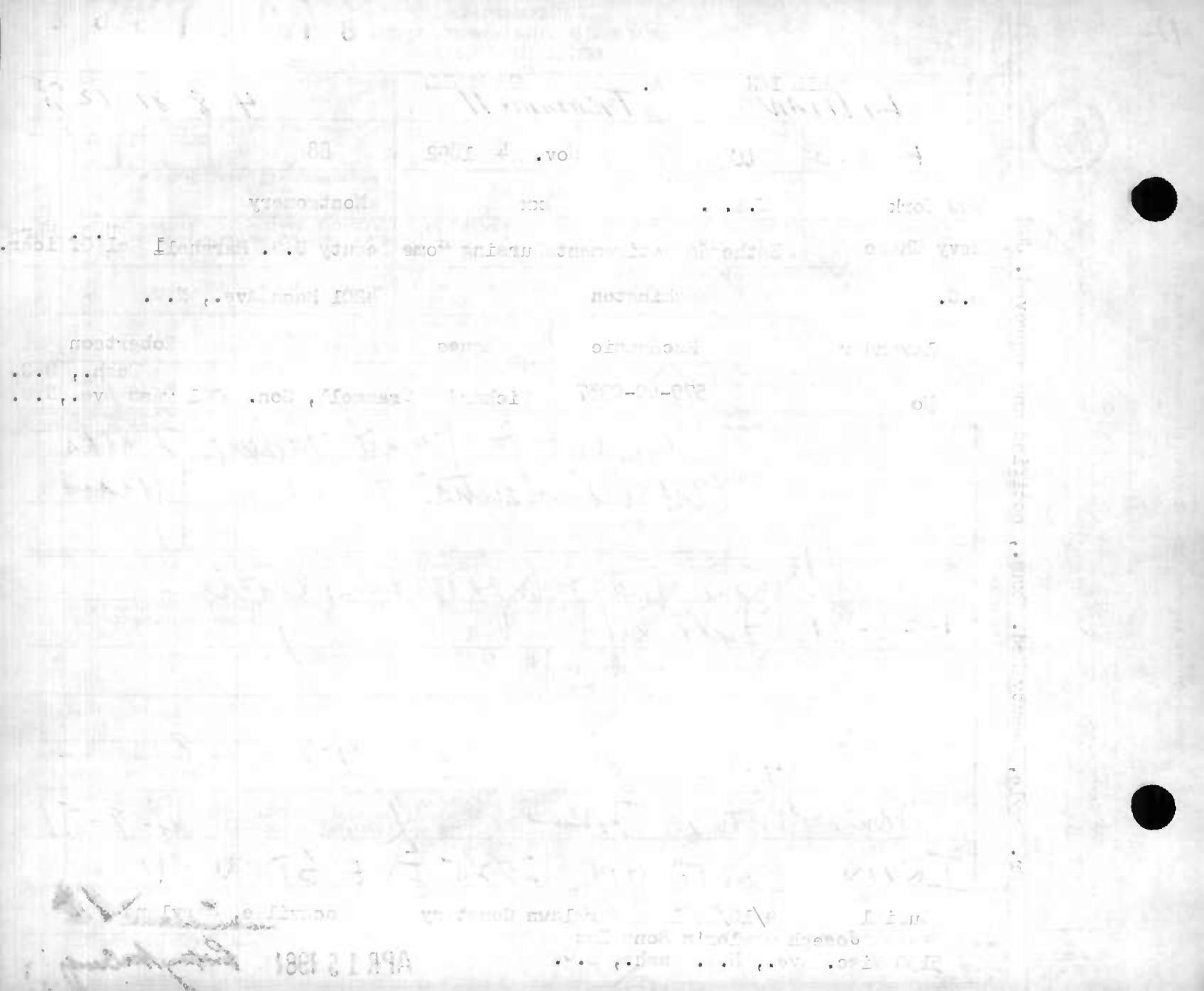
REG. NO.

|   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN A. TRAMMELL</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>8</b> YEAR <b>81</b> |  |  | 2b. HOUR<br><b>12 05 AM</b>  |  |  |  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |   | 5 DATE OF BIRTH<br>MONTH <b>Nov.</b> DAY <b>4</b> YEAR <b>1892</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                       |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Retirement &amp; Nursing Home</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Deputy U.S. Marshall</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Marshall al Officer.</b>  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>D.C.</b> 13b. COUNTY <b>Washington</b>   |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br><b>4201 Mass Ave., N.W.</b>   |  |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST <b>Alexander</b> MIDDLE <b></b> LAST <b>Mackenzie</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Agnes</b> MIDDLE <b></b> LAST <b>Robertson</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |  |  |   | 16b. SOCIAL SECURITY NO<br><b>579-60-0937</b>  |  | 17 INFORMANT<br>ADDRESS <b>Wash., D.C.</b><br><b>Richard A Trammell, Son. 4201 Mass Ave., N.W.</b> |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>2 wks</b><br>(b) <b>Arteriosclerotic H D</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>years.</b><br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF <b></b> |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Myocardial Infarction, Revere</b>   |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-26-81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Back. hip</b>   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-13-81</b> to <b>4-7-81</b> , that (I) (we) lost above (I) (we) (did) (did not) see the body after death. <b>1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Irving Brotman</b>   |  |  |   | DEGREE <b></b>   |  |  |  | 22c. DATE SIGNED<br><b>4-8-81</b>  |  |  |  |
| 24a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>IRVING BROTMAN</b>  |  |  |   | 22e. ADDRESS<br><b>2025 Eye St. N.W.</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/10/1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Rockville, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph Gawler's Sons Inc</b><br><b>5130 Wisc. Ave., N.W. Wash., D.C.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 15 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barry H. H. H.</b>  |  |  |  |  |  |

Dr. Mayle, Deputy Med. Exam., notified and approved. JGS 909 4/10/81

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 81 11063  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HUNTER H. TRAYLOR</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-26-81</b>  |  | 2b. HOUR<br><b>5:17 A</b> M   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12-8-10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>70 YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DRUG CLERK WASH. MED. CENTER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PHARMACY</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HERBERT L. TRAYLOR</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LUCILLE HOLLAND</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>578-09-6908</b>  |  | 17. INFORMANT ADDRESS<br><b>FRANCES L. TRAYLOR SAME AS 13 WIFE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b><br>5570<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>few days</b> |  |  |  |   |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Myeloproliferative Disorder</b> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> 19 <b>81</b> , to <b>4/26</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (I) did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Antonio G. Uy</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/26/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANTONIO G. Uy M.D.</b>  |  | 22e. ADDRESS<br><b>831 Univ. Blvd. Silver Spring, Md 20903</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/29/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLENWOOD CEMETERY</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WASHINGTON, D. C.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>FRANCIS J. COLLINS</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pistay McBrady</b>   |  |
| 2000 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |  |  |   |  |   |  |

171

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 1 0 6 4   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lucille Young TURNER</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 2, 1981</b>   |  | 2b. HOUR<br><b>5:00A</b> M   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 2, 1885</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co.,</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clarksburg</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>13200 Cool Brook Lane</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales clerk</b>                                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dress shop</b>   |  |   |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Clarksburg</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James T. Young</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Bevans</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>286-12-9290A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sara T. Hite, Item 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 years</b>  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/30</b> , 19 <b>74</b> , to <b>4/2</b> , 19 <b>81</b> , that (if <del>not</del> ) lost saw the deceased alive on <b>3/15</b> , 19 <b>81</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James P. Kerr, M.D.</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>April 2, 1981</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James P. Kerr, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>26618 Ridge Rd., Damascus, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>April 2, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Olin L. Molesworth, P.A.</b> ADDRESS <b>Damascus, Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 6 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey M. Brady</b>  |  |

1992 1993 1994

557

C. 12. 1994

0-80967-00

2

1998, 1999

END PAGE 1000

•

• •

— 5 —

}

1997, S. 1114

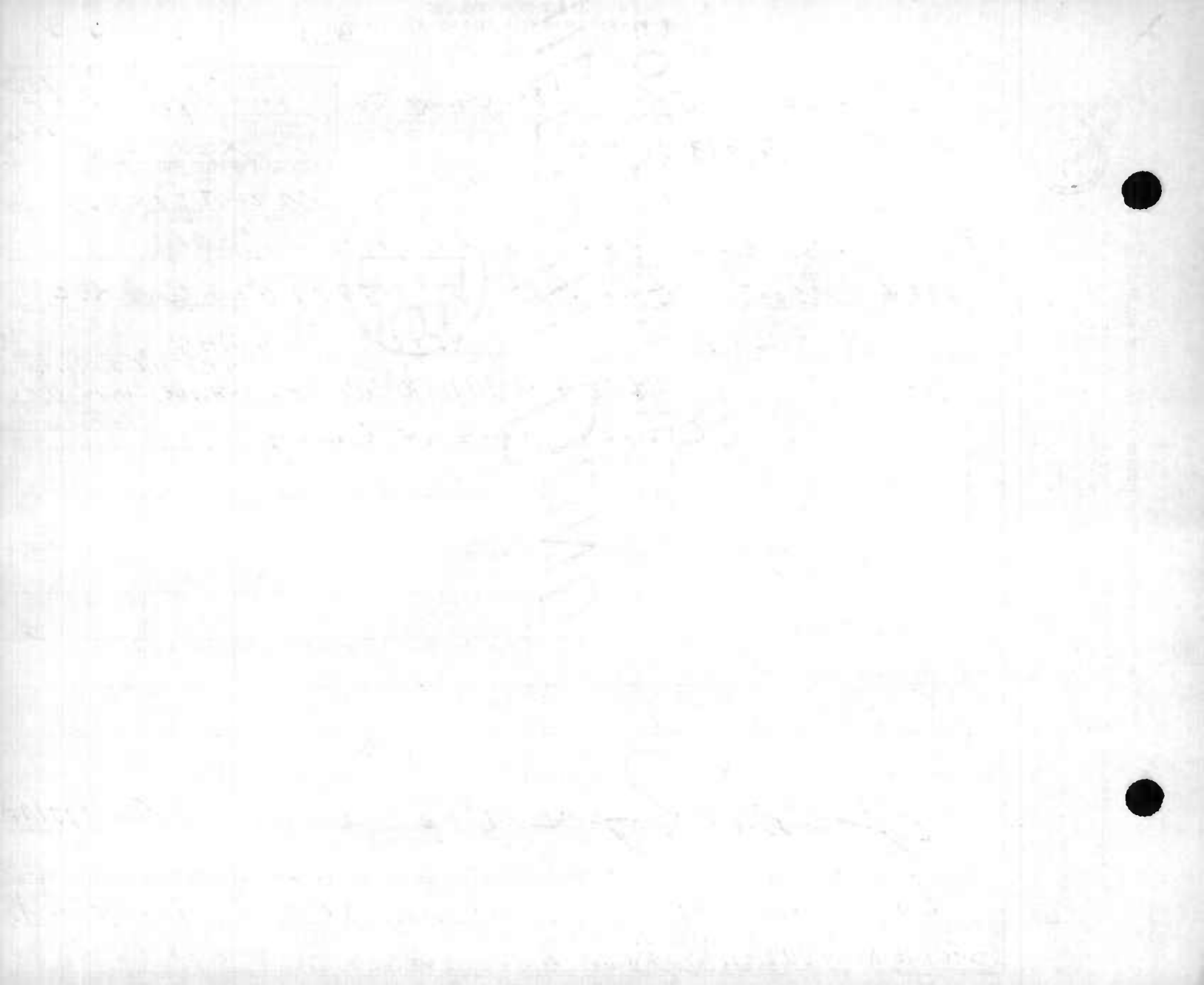
• 2019 年 10 月 1 日 起 施 行



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

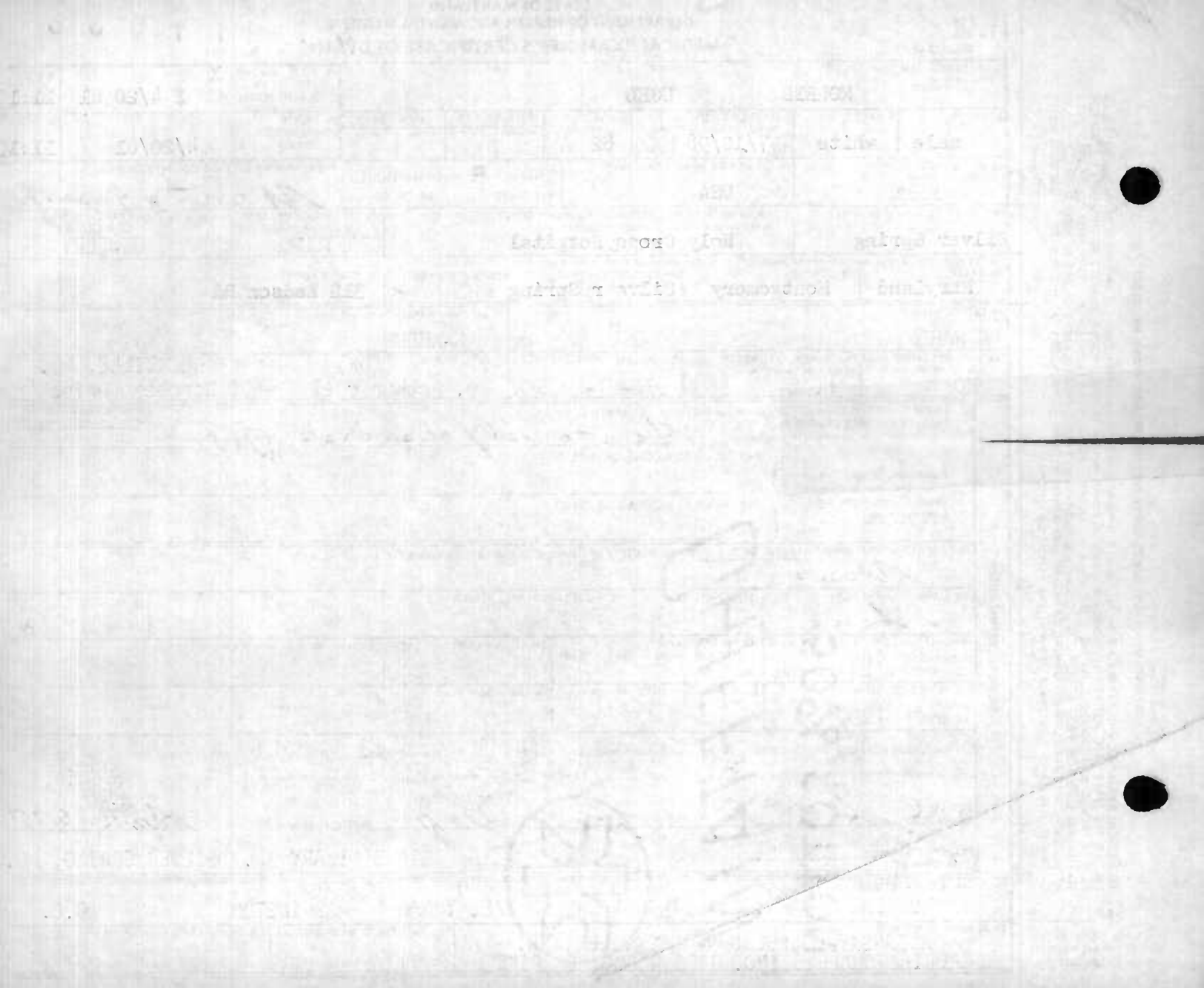
## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |  |                             |  |  |  |  | REG. NO. 11065                                |  |
|--|------------------|--|--|--|-----------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Samuel J. Twyman Jr.</b>   |                  |  |  |  |                             |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>April 13, 1981</b> |  |
| 3. SEX <b>M</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH (MONTH DAY YEAR) <b>Sept 13 31 49</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS. | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD <b>April 23, 1981</b>   |  | 2b. HOUR <b>9 AM</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Tak. Park</b>   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8221 Garland Ave.</b> |  |  |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stone mason</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |  |  |                             |  |  |  |  |   |  |
| 13a. STATE <b>MD</b>   |                  | 13b. COUNTY <b>Montg</b>   |  | 13c. CITY OR TOWN <b>Tak Park</b>  |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2907 Garland Ave.</b>                                     |  |   |  |
| 14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE LAST   |                  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Nettie Twyman</b> MIDDLE LAST <b>D.</b>  |                             |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO. <b>230-26-4881</b>  |                             | 17. INFORMANT ADDRESS <b>Myrtle Twyman Gaithersburg, Md.</b>                                 |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                  |  |  |  |                             |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |                  |  |  |  |                             |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                             |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                             |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                             |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |  |                             |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John R. Rogers</b>   |                  |  |  | TITLE (SPECIFY) <b>M.D. Day</b>  |                             | MEDICAL EXAMINER   |  | DATE SIGNED <b>April 23 1981</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |                  | ADDRESS  |  |  |                             |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                  | 23b. DATE <b>4-28-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cem.</b>  |                             | 23d. LOCATION CITY OR TOWN <b>Rockville</b> COUNTY <b>Montg</b> STATE <b>Md.</b>             |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b> ADDRESS <b>246 N. Wash. St. Rockville, Md.</b>  |                  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 28 1981</b>   |                             | 25b. REGISTRAR'S SIGNATURE <b>Timothy McHenry</b>  |  |  |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |  |  |   |   |  |  |  | REG. NO. 11066 |  |
|--|----------------------|--|--|--|---|---|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MORRIS UGEL</b>   |                      |  |  |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>4</b> DAY <b>20</b> YEAR <b>81</b> |  | 2b. HOUR <b>11:10</b>                            |  |                |  |
| 3. SEX <b>male</b>   | 4. RACE <b>white</b> | 5. DATE OF BIRTH<br>MONTH <b>JAN.</b> DAY <b>10</b> YEAR <b>1899</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS. | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD <b>4/20/81</b>   |  | 2d. HOUR <b>11:10</b>                            |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>   |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CRAFTSMAN</b>                          |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b> |  |                |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>312 Ladson Rd</b>  |                      |  |  |  |   |   |  |  |  |                |  |
| 14. FATHER'S NAME<br>FIRST <b>ABRAHAM</b> MIDDLE <b></b> LAST <b>UGEL</b>  |                      |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b>UNKNOWN</b>   |   |   |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |                      | 16b. SOCIAL SECURITY NO. <b>578-01-0005 A</b>  |  | 17. INFORMANT (SON) <b>Dr. Arthur Ugel</b>   |   | ADDRESS <b>ROCKVILLE, MD. 4808 Hornbeam Drive</b>   |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4391</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>            |                      |  |  |  |   |   |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |                      |  |  |  |   |   |  |  |  |                |  |
| 19a. DATE OF OPERATION <b>None</b>   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |  |  |  |   |   |  |  |  |                |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |                      | TITLE (SPECIFY) <b>MD. Dep.</b>  |  |  |   | MEDICAL EXAMINER  |  | DATE SIGNED <b>April 20 1981</b>                 |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>  |                      | ADDRESS <b>1919 SEMINARY RD., SILVER SPRING, MD.</b>   |  |  |   |   |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                      | 23b. DATE <b>APR. 22, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>OSHEV SHOLOM TAL. TORAH</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WASHINGTON D.C.</b>                                    |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>DANZANSKY-GOLDBERG</b> ADDRESS <b>ROCKVILLE, MD. MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE</b>  |                      | 25a. DATE REC'D. BY REGISTRAR <b>APR 24 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |   |   |  |  |  |                |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                              |   |                  |  |   |  |                                      |   | REG. NO. 11067                               |  |
|---|--|------------------------------|---|------------------|--|---|--|--------------------------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST MIDDLE LAST   |                  |  | 2a. DATE KNOWN OF DEATH   |  |                                      | 2b. HOUR  |  |  |
| Grant   |  |                              | S   |                  |  | Uhl   |  |                                      | 2b. HOUR  |  |  |
| 3. SEX  |  | 4. RACE                      |   | 5. DATE OF BIRTH |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                       |   | IF UNDER 24 HRS.                             |  |
| MALE  |  | White                        |   | 4-6-32           |  | 49 YRS.   |  | MONTHS                               |   | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED       |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   | 2d. HOUR                                     |  |
| WASHINGTON, D.C.  |  | U.S.A.                       |   | WIDOWED          |  | DIVORCED  |  | Montgomery                           |   | 2d. HOUR                                     |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Bethesda  |  |                              | Suburban Hospital   |                  |  | ACCOUNTANT  |  |                                      | SELF-EMP.   |  |  |
| 13a. STATE  |  |                              | 13b. CITY OR TOWN   |                  |  | 13c. INSIDE CITY LIMITS?  |  |                                      | 13d. STREET ADDRESS   |  |  |
| MD  |  |                              | MONTGOMERY  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |                                      | 6305 POE RD   |  |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME                                    |                  |  | 16a. SOCIAL SECURITY NO.  |  |                                      | 17. INFORMANT   |  |  |
| HARRY GRANT   |  |                              | MILDRED GINN  |                  |  | 578-42-6798   |  |                                      | IRENE T. UHL  |  |  |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |                              | 16c. SOCIAL SECURITY NO.                                    |                  |  | 17. INFORMANT   |  |                                      | ADDRESS   |  |  |
| YES   |  |                              | 1954/1956   |                  |  | IRENE T. UHL  |  |                                      | SAME AS # 13  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |   |                  |  |   |  |                                      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1 DEATH WAS CAUSED BY:   |  |                              |   |                  |  |   |  |                                      |   | ACUTE  |  |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION   |  |                              |   |                  |  |   |  |                                      |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |   |                  |  |   |  |                                      |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                              |   |                  |  |   |  |                                      |   |  |  |
| (b) ARTERIOSCLEROSIS GENERALIZED  |  |                              |   |                  |  |   |  |                                      |   | INDEF.                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |   |                  |  |   |  |                                      |   |  |  |
| (c)   |  |                              |   |                  |  |   |  |                                      |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                              |   |                  |  |   |  |                                      |   |  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |  |   |  |                                      | 20. AUTOPSY?  |  |  |
|   |  |                              |   |                  |  |   |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                              | 21b. TIME OF INJURY   |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                      |   |  |  |
| R   |  |                              | HOUR A.M. MONTH DAY YEAR                                    |                  |  | COLLAPSED IN YARD   |  |                                      |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  |  | 21f. LOCATION   |  |                                      |   |  |  |
|   |  |                              | HOME  |                  |  | 6305 POE RD BETHESDA MONT MD  |  |                                      |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                              |   |                  |  |   |  |                                      |   |  |  |
| ACTUAL SIGNATURE  |  |                              | TITLE (SPECIFY)   |                  |  | DATE SIGNED   |  |                                      |   |  |  |
| Francis C. Mayle  |  |                              | Dept  |                  |  | 4/24/81   |  |                                      |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |                              | ADDRESS   |                  |  |   |  |                                      |   |  |  |
| FRANCIS C. MAYLE  |  |                              | 8200 WISCONSIN AVE BETHESDA MD                              |                  |  |   |  |                                      |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE   |                  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                      | 23d. LOCATION   |  |  |
| BURIAL  |  |                              | 4-27-81   |                  |  | CEDAR HILL CEM.   |  |                                      | SUITLAND P.G.CO. MD.  |  |  |
| 24. FUNERAL DIRECTOR  |  |                              |   |                  |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                      | 25b. REGISTRAR'S SIGNATURE  |  |  |
| JOS. GAWLER'S SONS 5130 WISC.AVE.NW WASH., D.C.   |  |                              |   |                  |  | APR 27 1981   |  |                                      | [Signature]   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0703 BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 1 0 6 8   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |   |  |
| FIRST MARIAN A LAST Waite  |  |  |  | MONTH DAY YEAR April 20, 1981   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR March 8, 1933  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Derwood  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Not Available  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Tillina Messinia   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>577-44-4812   |  |   |  |
| 17. INFORMANT<br>Don A. Waite (Same as 13e)  |  |  |  | ADDRESS   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per part I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DOE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diffuse Bronchial alveolar carcinoma</u><br>3mo<br>DOE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u> |  |  |  |   |  |   | 18. CAUSE OF DEATH (Enter only one cause per part I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DOE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diffuse Bronchial alveolar carcinoma</u><br>3mo<br>DOE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4/20/81</u> to <u>4/20/81</u> , that (I) (we) lost saw the deceased alive on <u>4/20/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Robert C. Macon</u>   |  |  |  | 22c. DEGREE<br>M.D.   |  | 22d. DATE SIGNED<br>4/21/81   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert C. Macon   |  |  |  | 22f. ADDRESS<br>809 Viers Mill Rd. Rockville, Md 20851  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  | 23b. DATE<br>April 23, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME Robert A. Pumphrey<br>ADDRESS P.A., Rockville, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1981  |  |   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McBrady</u>   |  |   |  |



1951-1952  
1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

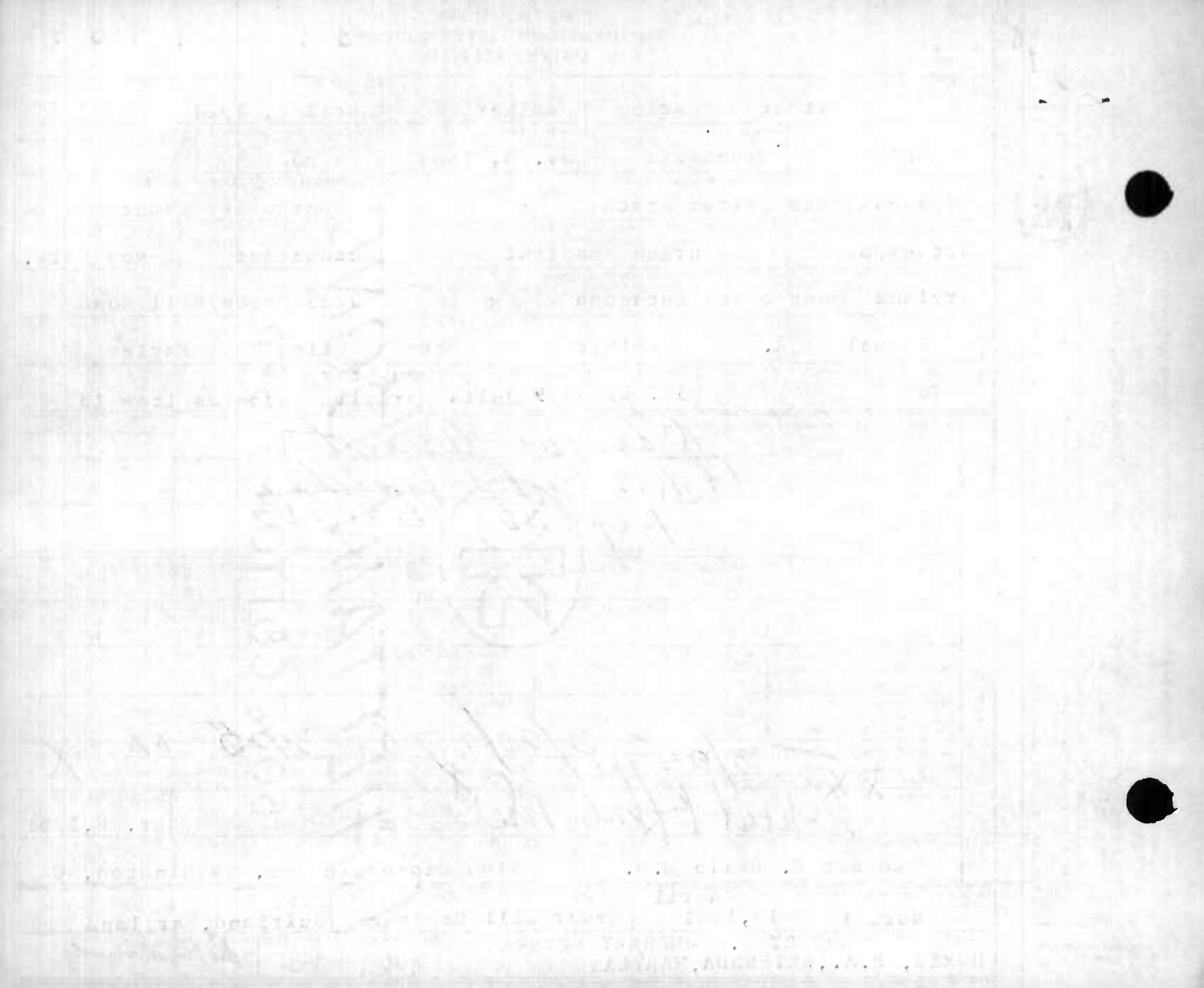
|   |  |   |   |   |                                      |   |   |  |  |
|---|--|---|---|---|--------------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Arthur Earley Walker</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 7, 1981</b>               |   |                                      | 2b. HOUR<br>P<br><b>11:35M</b>  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 3, 1885</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Exxon Corp.</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Bethesda</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel A. Walker</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ellen Earley</b> |   |                                      | 13e. STREET ADDRESS<br><b>5225 Pooks Hill Road</b>                                    |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577 09 0509</b>  |   | 17. INFORMANT<br><b>Daughter</b>  |                                      | ADDRESS<br><b>same as item 13</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4039</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Chronic Cardiovascular -</b><br>(c) <b>Myocardial sclerosis</b> |  |   |   |   |                                      |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |                                      |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |                                      | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <b>3/25/81</b> to <b>3/25/81</b> that (2) (the last saw the deceased alive on <b>3/25/81</b> and that (3) (my) opinion death occurred on the date and hour and from the causes stated above. (If (1) or (2) could not view the body after death, so state.)                   |  |   |   |   |                                      |   |   |  |  |
| 22b. SIGNATURE<br><b>Robert C. Haile M.D.</b>   |  |   | DEGREE  |   |                                      | 22c. DATE SIGNED<br><b>Apr. 8, 1981</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert C. Haile M.D.</b>  |  |   | 22e. ADDRESS<br><b>5100 Wisconsin Ave. Washington, DC</b>                 |   |                                      |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 10, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Maryland</b>               |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>   |  |   |   |   |                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert C. Haile</b>   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>1- STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 0 7 0  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Grover K. Walker   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 6, 1981  |  |   |  | 2b. HOUR<br>12:28 AM   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 18, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | 8. UNDER 1 YEAR<br>MONTHS DAYS   |  | 9. UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer-Dairyman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Farmer   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Gaithersburg   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6 Rolling Knoll Ct.<br>Gaithersburg, Md. 20760  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>McKendree - Walker  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rachael Corinne Holland  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT<br>ADDRESS<br>6 Rolling Knoll Ct.,<br>Gaithersburg, Md.   |  | 17. INFORMANT<br>Marian W. Walker   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>arteriosclerotic cardiovascular disease</u><br>(c) <u>years</u>                |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>moment</u>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes mellitus</u>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |   |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>68</u> , to <u>April</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>March 5</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>Delbert E. DeLaater, MD</u>  |  |   |  | DEGREE<br>MD  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>April 6, 1981</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Delbert E. DeLaater, MD</u>   |  |   |  | 22e. ADDRESS<br><u>5500 Friendship Blvd Chevy Chase Md 20015</u>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br><u>4/9/81</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Forest Oak Cemetery</u>  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br><u>Gaithersburg Montg. Md.</u>              |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Gartner Sandison F.H. Gaithersburg, Md.</u>  |  |   |  | 24b. ADDRESS<br><u>316 E. Diamond Ave.</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 13 1981</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for recording in the death record. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 4 should be retained by the funeral director. IMPORTANT: If item 21 is marked or item 19 shows any injury or illness, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 8111071  |  |   |  |   |  |  |  |  |  |
| 1- FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
| REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>John A. Ward</u>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>April 10 1981</u>             |  | 2b. HOUR<br><u>1:10 A.M.</u>                       |  |  |
| 3. SEX<br><u>male</u>  |  | 4. RACE<br><u>white</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>8 2 03</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>77</u> YRS.                                    |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>England</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery County MD.</u>                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring Md.</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS)<br><u>St. Mary's Hospital</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Retired</u>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Condition</u>  |  |
| 13a. STATE<br><u>Md.</u>   |  |   |  |   | 13b. CITY OR TOWN<br><u>Montgomery Sil. Spr.</u>                     |  | 13c. STREET ADDRESS<br><u>2105 Belvedere Blvd.</u> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>John James Ward</u>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Elizabeth Battk</u> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>no</u>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><u>578 01 2323</u>                                  |  | 17. INFORMANT ADDRESS<br><u>Margaret E. Ward (same as #13)</u>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>POST-OPERATIVE MYOCARDIAL INFARCTION</u><br>4100 } DUE TO, OR AS A CONSEQUENCE OF<br>CORONARY ARTERY DISEASE<br>(b) <u>CORONARY ARTERY DISEASE</u><br>(c) <u>4100</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 MINS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>4/9/81</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>ABDOMINAL AORTIC ANEURYSM</u>                        |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> 19 <u>81</u> , to <u>4/10</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4/10</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>John Korloff MD</u>   |  |   |  |   | DEGREE<br><u>MD</u>  |  |  | 22c. DATE SIGNED<br><u>4/10/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Louis Korloff, M.D.</u>  |  |   |  |   | 22e. ADDRESS<br><u>8218 Wisconsin Ave. Bethesda, Md. 20014</u>       |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>4/13/81</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery Suitland</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Pr. Ga. Md.</u>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Warner E. Pumphrey</u>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 15 1981</u>                  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |   |  |  |  |  |  |

APR 12 1981

*[Handwritten signature]*

James K. [unclear]

James K. [unclear]

4/10/81

4/10

James K. [unclear]

James K. [unclear]

James K. [unclear]

John

James K. [unclear]

James K. [unclear]

James K. [unclear]

James K. [unclear]

James K. [unclear]

James K. [unclear]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M  
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |   | 8 1 1 1 0 7 2   |   |
|--|---|---|---|---|---|
| 1. FOR STATE REGISTRAR   |   |   |   | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MATILDA E WARNER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>81</b>                                 |   | 2b. HOUR <b>6:15</b> M  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH <b>AUG</b> DAY <b>31</b> YEAR <b>1906</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                            |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>MONTGOMERY</b>  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3603 S. LEISURE WORLD BLVD.</b>                               |   |
| 14. FATHER'S NAME<br>FIRST <b>VALENTINE</b> MIDDLE <b></b> LAST <b>EHMANN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>EMMA</b> MIDDLE <b></b> LAST <b>SCHEG</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-64-5374</b>  |   | 17. INFORMANT<br><b>SON</b> ADDRESS<br><b>3707 SHEPHERD STREET<br/>CHEVY CHASE, MD.</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary Fibrillation</b><br><b>3989</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Chronic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Chronic Obstructive Pulmonary Disease</b>  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>February</b> 19 <b>81</b> , to <b>April</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>April</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |   |   |   |   |   |
| 23a. SIGNATURE<br><b>Barton J. Gershen</b>   |   | DEGREE  |   | 23c. DATE SIGNED<br><b>4/2/81</b>   |   |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARTON J. GERSHEN</b>   |   | 25a. ADDRESS<br><b>50 West Edmonston Drive Rockville, MD</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>4/4/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>                                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT MD.</b> |
| 24. FUNERAL DIRECTOR NAME<br><b>FRANCIS J. COLLINS</b>   |   | 25b. DATE REC'D. BY REGISTRAR<br><b>APR 03 1981</b>   |   | 25c. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |
| 26. ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |   |   |   |   |   |

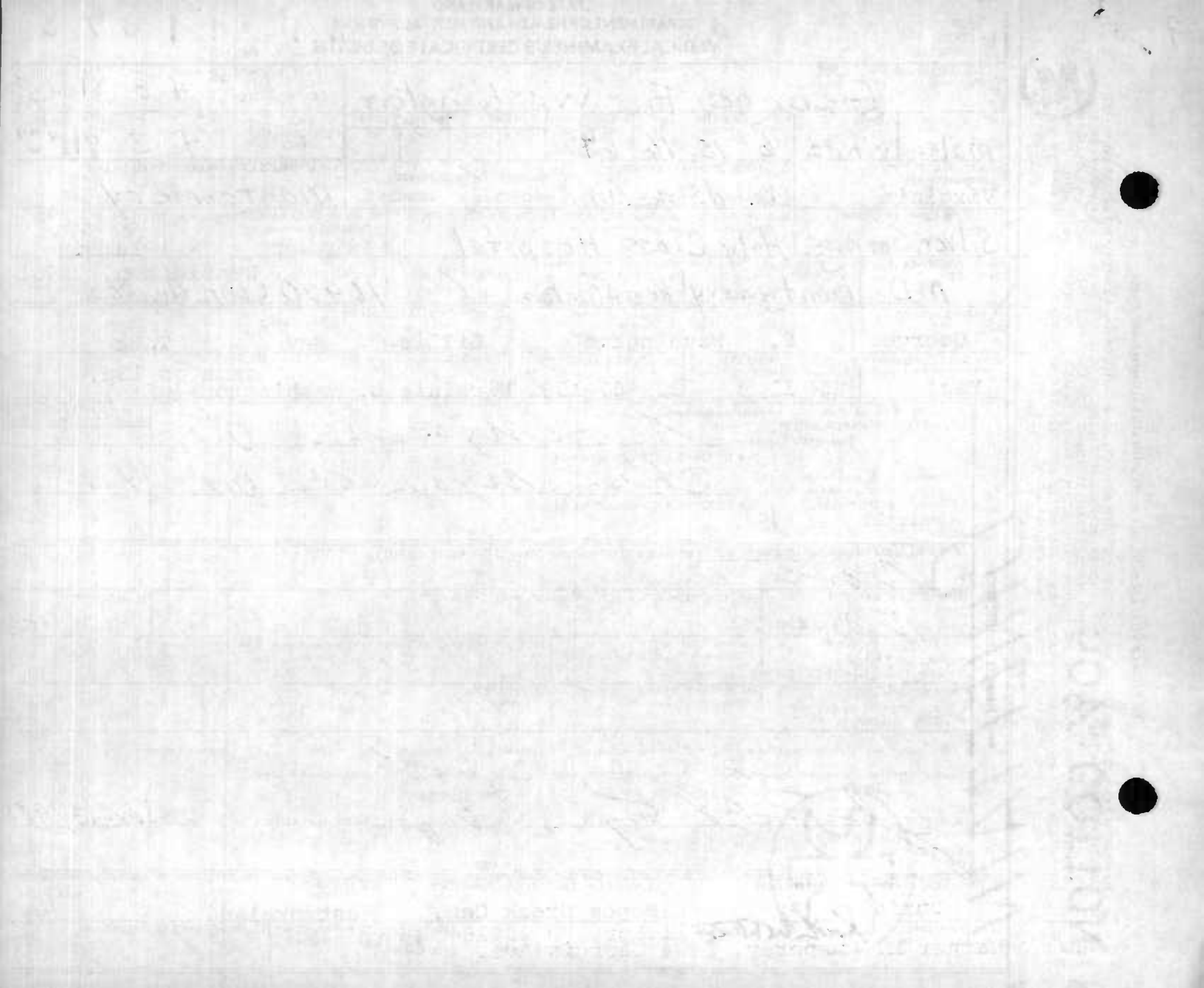
BP



1981 03 09

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |         |  |                  |  |  |  |                |  |                  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                   |  |  |  |                                      |  |   |  |  |  |  |  | REG. NO. |  |
|--|--|---------|--|------------------|--|--|--|----------------|--|------------------|--|--|--|--|--|--------------------------------------|--|---|--|--|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |                  |  | FIRST MIDDLE LAST  |  |                |  |                  |  | 2a. DATE KNOWN OF DEATH  |  |  |  | 2b. HOUR                             |  |   |  |  |  |  |  |          |  |
| George F. Washington   |  |         |  |                  |  |  |  |                |  |                  |  | MONTH DAY YEAR   |  |  |  | 4 3 81                               |  |   |  |  |  |  |  |          |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD   |  |  |  | 2d. HOUR                             |  |   |  |  |  |  |  |          |  |
| male   |  | white   |  | 6 15 16 68       |  | LAST (DAY) YRS.  |  | MONTHS         |  | DAYS             |  | MONTH DAY YEAR   |  |  |  | 4 3 19 81                            |  |   |  |  |  |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  |                |  |                  |  | 8. MARRIED   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |  |  |  |  |          |  |
| Virginia   |  |         |  |                  |  | United States Am.  |  |                |  |                  |  | WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | Montgomery MD                        |  |   |  |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |                |  |                  |  | 12a. USUAL OCCUPATION  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |   |  |  |  |  |  |          |  |
| Silver Springs   |  |         |  |                  |  | Holy Cross Hospital                                      |  |                |  |                  |  | Plumber  |  |  |  | Plumbing                             |  |   |  |  |  |  |  |          |  |
| 13a. STATE   |  |         |  |                  |  | 13b. COUNTY  |  |                |  |                  |  | 13c. CITY OR TOWN  |  |  |  |                                      |  | 13d. INSIDE CITY LIMITS?  |  |  |  |  |  |          |  |
| MD   |  |         |  |                  |  | Montgomery   |  |                |  |                  |  | Kensington   |  |  |  |                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |          |  |
| 14. FATHER'S NAME  |  |         |  |                  |  | 15. MOTHER'S MAIDEN NAME                                 |  |                |  |                  |  | 13e. STREET ADDRESS  |  |  |  |                                      |  | 13f. CITY OR TOWN   |  |  |  |  |  |          |  |
| George F. Washington   |  |         |  |                  |  | Lillie May Tate  |  |                |  |                  |  | Kensington, 20795  |  |  |  |                                      |  | Conn. Av. 302   |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |         |  |                  |  | 16b. SOCIAL SECURITY NO.                                 |  |                |  |                  |  | 17. INFORMANT  |  |  |  |                                      |  | ADDRESS   |  |  |  |  |  |          |  |
| Yes  |  |         |  |                  |  | WW 11  |  |                |  |                  |  | 229-07-1582  |  |  |  |                                      |  | Virginia L. Washington-(wife)                                       |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |  |  |          |  |
| PART 1 DEATH WAS CAUSED BY:  |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| IMMEDIATE CAUSE (a)  |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| 4291 Acute Myocardial Dis.   |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| (b) Chronic Myocardial Dis.  |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  | 4 yr.   |  |  |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| (c)  |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| None   |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |         |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |                |  |                  |  | 20. AUTOPSY?   |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| None   |  |         |  |                  |  |  |  |                |  |                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS  |  |         |  |                  |  | 21b. TIME OF INJURY                                      |  |                |  |                  |  | 21c. HOW INJURY OCCURRED   |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |                  |  | HOUR A.M. MONTH DAY YEAR                                 |  |                |  |                  |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2   |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
|  |  |         |  |                  |  | P.M. 19  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED   |  |         |  |                  |  | 21e. PLACE OF INJURY                                     |  |                |  |                  |  | 21f. LOCATION  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |         |  |                  |  | STREET, FACTORY, FARM, ETC.)                             |  |                |  |                  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| ACTUAL SIGNATURE   |  |         |  |                  |  | TITLE (SPECIFY)  |  |                |  |                  |  | DATE SIGNED  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| [Signature]  |  |         |  |                  |  | M.D. Dep.  |  |                |  |                  |  | April 13, 1981   |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| EXAMINER'S NAME  |  |         |  |                  |  | ADDRESS  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| (TYPE OR PRINT)  |  |         |  |                  |  |  |  |                |  |                  |  |  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |                  |  | 23b. DATE  |  |                |  |                  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |                                      |  | 23d. LOCATION   |  |  |  |  |  |          |  |
| Burial   |  |         |  |                  |  | Apr. 5, 1981   |  |                |  |                  |  | Popes Creek Cem.   |  |  |  |                                      |  | Westmoreland Va.  |  |  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                  |  | 25a. DATE RECEIVED BY REGISTRAR                          |  |                |  |                  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                                      |  |   |  |  |  |  |  |          |  |
| Warner E. Pumphrey, 8434 Georgia Ave.  |  |         |  |                  |  | APR 9 1981   |  |                |  |                  |  | [Signature]  |  |  |  |                                      |  |   |  |  |  |  |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

DHMH: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MORRIS WASSERMAN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 29, 1981 |   |  | 2b. HOUR<br>10 <sup>40</sup> AM   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOVEMBER 4, 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TAXI DRIVER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF EMPLOYED  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>LEON   |  | 15. MOTHER'S MAIDEN NAME<br>ROSE   |   | 13e. STREET ADDRESS<br>1131 University Blvd.  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II 577-10-4976   |   | 17. INFORMANT<br>ADDRESS<br>MELRAE WASSERMAN, 1131 UNIVERSITY BOULEVARD, WEST - SILVER SPRING, MD.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hypertensive atherosclerotic heart</u><br>(c) <u>Cholesterol atherosclerosis</u> |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES TO HOURS<br>YES<br>YES |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>75</u> , to <u>April 29</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>ACBENT H. GROCHMAN, MD  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>4/29/81   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |  |   | 23b. DATE<br>5/1/1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>KING DAVID MEMORIAL GARDEN  |  |
| 23d. LOCATION<br>FALLS CHURCH, VIRGINIA   |  |  |   | 23e. DATE REC'D. BY REGISTRAR   |  |   |  |
| 24. FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |  |   | 25. REGISTRAR'S SIGNATURE   |  |   |  |

RECEIVED

1911

NOV 1 1911

XX

RECEIVED

NOV 1 1911

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |   |  | jlb DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 1 0 7 5                |   |  |  |   |  |   |  |  |                                   |  |
|---|--|--|---|--|--|---|--|--|---|--|---|--|--|-----------------------------------|--|
| Item 1 - G558, 8-20-81  |  |  |   |  | CERTIFICATE OF DEATH   |   |  |  |   |  |   |  |  |                                   |  |
| REG. NO.  |  |  |   |  |  |   |  |  |   |  |   |  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MABEL I. WELDE</b>   |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-3-81</b>                     |   |  |  |   | 2b. HOUR<br><b>12:35 PM</b>  |   |  |  |                                   |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Caucasian</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 23 1894</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.   |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |   |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GAITH</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WILSON HEALTH CARE CENTER</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Research - History</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nat. Archives</b>                                       |  |   |  |  |                                   |  |
| 13a. STATE<br><b>Md.</b>  |  |  |   |  | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b>                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>100 E. Church St.</b> |  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George - Welde</b>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida C. Haightout</b> |   |  |  |   |  |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>  |  |  | 17. INFORMANT<br><b>Beverly Craig</b>   |  |  | 18. ADDRESS<br><b>301 Russell Ave., Gaithersburg, Md. 20760</b>                                 |  |   |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest.</b><br><b>4370</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Bronchiopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diffuse cerebral arteriosclerosis</b> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 min</b><br><b>7 d.</b><br><b>2 yrs.</b> |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Rectal bleeding of unknown cause.</b>   |  |  |   |  |  |   |  |  |   |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |   |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |                                   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 19 80</b> , to <b>April 3 19 80</b> , that (1) (we) last saw the deceased alive on <b>April 1 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.   |  |  |   |  |  |   |  |  |   |  |   |  |  |                                   |  |
| 22b. SIGNATURE<br><b>James B. Moore</b>   |  |  |   |  |  |   |  |  |   | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-3-81</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James B. Moore</b>  |  |  |   |  |  |   |  |  |   | 22e. ADDRESS<br><b>207 Brookes Ave Gaithersburg Md.</b>                                      |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  |   |  | 23b. DATE<br><b>April 4, '81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D. C.</b>                       |   |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>Name <b>Robert J. Sandison</b><br><b>GARTNER SANDISON</b>   |  |  |   |  | 316 E. Diamond Ave.<br><b>Gaithersburg, Md.</b>                          |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 9 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert J. Sandison</b>  |  |                                   |  |



0 1 0005722511

2012年11月25日

• *Chrysomelidae*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |   |  |
|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Olive Mae WELLS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 10 1981</b>         |   | 2b. HOUR<br><b>4:45A</b>                        |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 28 1924</b>  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maine</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |   |  |
| 13a. STATE<br><b>Virginia</b>   |  |   | 13b. CITY OR TOWN<br><b>Pr. William Dumfries</b>                    |   | 13c. STREET ADDRESS<br><b>15716 Vista Drive</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William J. Carey</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nora Landry</b> |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |   | 17. INFORMANT<br><b>Robert Wells</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>Metastatic adeno carcinoma of colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>March 30</b> , 19 <b>81</b> , to <b>April 10</b> , 19 <b>81</b> that I (we) last saw the deceased alive on <b>April 10</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Gary Zaloga</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>April 10 1981</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary Zaloga, M.D.</b>   |  | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Apr. 13, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Va.</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 16 1981</b>   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Road B. Chis</b>   |  | 25. ADDRESS<br><b>Cunningham Mountcastle Funeral Home Va.</b>   |   |   |   |  |

BP

APR 18 1961

CHURCH

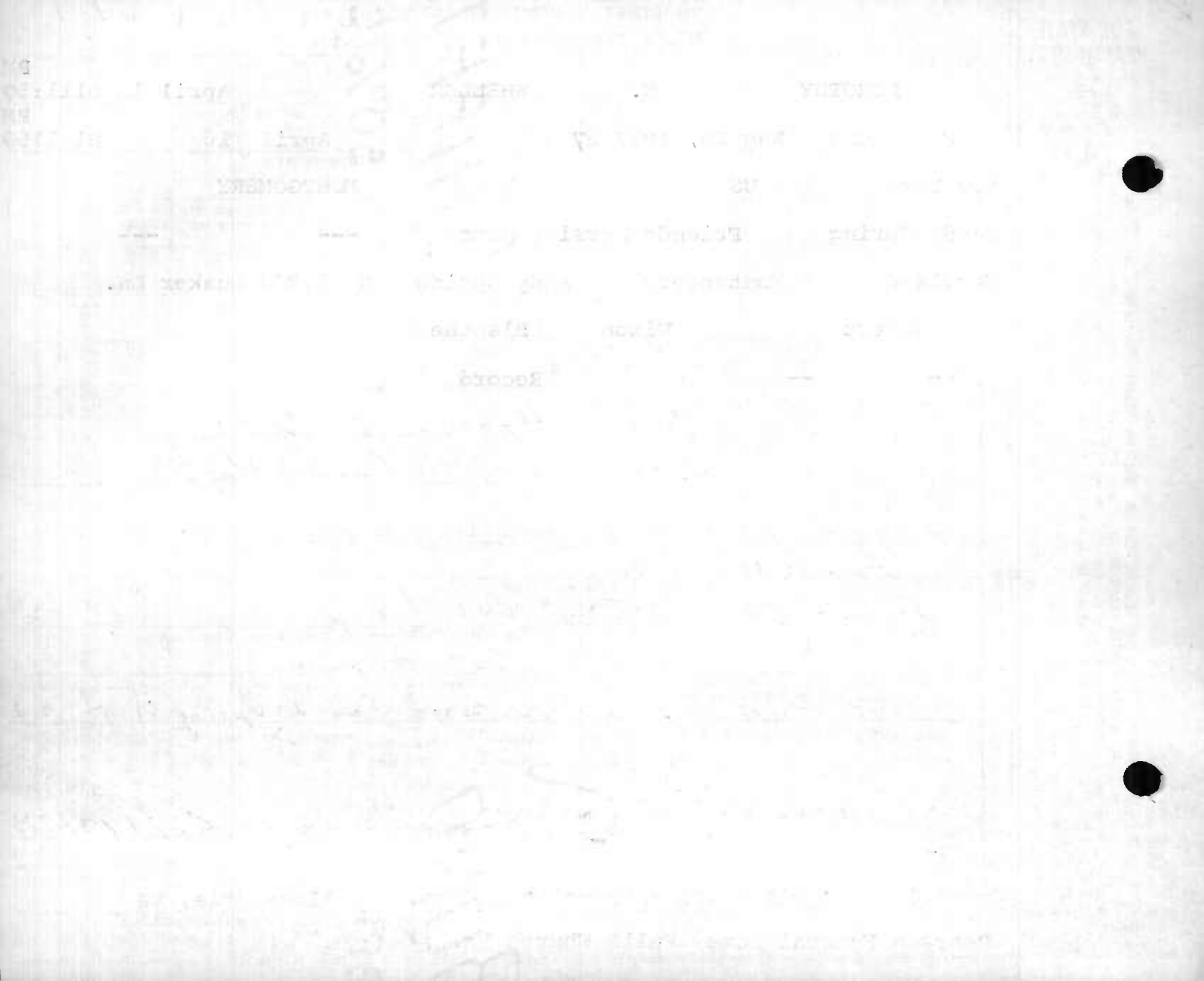
# FOR STATE HEALTH DEPT.

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11077

|  |                       |   |  |   |   |
|--|-----------------------|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br><b>DOROTHY N. WHEELER</b>   |                       |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month Day Year<br>MATED <input checked="" type="checkbox"/> <b>April 16 1981 11:50 PM</b> |   |   |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>Cau</b> | 5. DATE OF BIRTH<br><b>Aug 29, 1893</b>   | 6. AGE (In years last birthday)<br><b>87</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>   |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Sandy Spring</b>   |                       |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Friends Nursing Home</b>                                |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>---</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                       |   | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Sandy Spring</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |
| 14. FATHER'S NAME First Middle Last<br><b>Robert Nixon</b>   |                       |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Blanche</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>--</b>  |                       | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service) <b>144-07-2426</b>  |  | 17. INFORMANT<br><b>Record</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Acute Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) Arteriosclerotic Cardio. Vas. Dis. 4 yrs.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>                               |                       |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Fracture l hip</b>  |                       |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>Jan 2 81</b>  |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>fracture l. hip</b>  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |                       | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>12 28 80</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Not known</b>   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                       | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Nursing home</b>   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Norwood Sandy Spring Mont Md</b>   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                       |   |  |   |   |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)   |                       | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>April 17 1981</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                       | 23b. DATE<br><b>April 18, 81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crem.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Pearson Funeral Home</b>  |                       | ADDRESS<br><b>Falls Church Va.</b>  |  | 25a. RECEIVED BY REGISTRAR<br><b>APR 22 1981</b>  |   |
|  |                       |   |  | 25b. REGISTRAR'S SIGNATURE  |   |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL-RETAIN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 1 0 7 8  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>INFANT MALE WILKERSON</b>   |  |  |  | 2a. DATE OF DEATH MONTH <b>4</b> DAY <b>29</b> YEAR <b>81</b> 2b. HOUR <b>7:55 AM</b>  |  |   |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>APRIL</b> DAY <b>29</b> YEAR <b>1981</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS <b>3 11</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE ADDRESS) <b>HOLY CROSS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>PRINCE GEO.</b>   |  | 13c. CITY OR TOWN <b>RIVERDALE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME <b>JOHN M. WILKERSON</b>  |  | 15. MOTHER'S MAIDEN NAME <b>REBECCA MOORE</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>NONE</b>  |  | 17. INFORMANT ADDRESS <b>JOHN W. WILKERSON SAME AS #13 (FATHER)</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>respiratory failure</b> 7650  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>extreme immaturity</b>  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>premature birth</b>   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 29, 1981</b> , to <b>April 29, 1981</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b> MD DEGREE   |  |  |  | 22c. DATE SIGNED <b>4-29-81</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BL BARBARA JR MD</b>   |  |
| 22e. ADDRESS <b>Holy Cross Hospital</b>   |  |  |  | 23a. NAME OF CEMETERY <b>PROTESTANT</b>  |  |   |  |
| 23b. DATE <b>May 7, 1981</b>  |  | 23c. LOCATION CITY OR TOWN <b>Largo</b> COUNTY <b>Prince Georges</b> STATE <b>Md.</b>                                  |  | 24. FUNERAL DIRECTOR <b>Francis Casch's Sons Funeral Home, P.A.</b> ADDRESS <b>Hyattsville, Maryland</b>   |  |   |  |
| 25. DATE REC'D. BY REGISTRAR <b>MAY 6 1981</b>  |  |  |  | 26. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |

WILLIAM

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

MAY 1981

11/11



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                        |   |   |   |  |   |  |  |  | REG. NO. 11079 |  |
|---|------------------------|---|---|---|--|---|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RICHARD M. WILKINSON</b>   |                        |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>4 21 19 81</b>      |  | 2b. HOUR <b>P</b>                                |  |                |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>CAUC</b> | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>51</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>29</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD<br><b>4 21 19 81</b>   |  | 2d. HOUR <b>1:30</b>                             |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>INDIANA</b>   |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                      |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>   |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHESTNUT LODGE</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |  |                |  |
| 13a. STATE<br><b>MD</b>   |                        | 13b. COUNTY<br><b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>500 W. MONTGOMERY</b>  |  |                |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>R.</b> LAST <b>Wilkinson</b>  |                        |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jennie</b> MIDDLE <b></b> LAST <b>Gauda</b>  |  |   |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                        | (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.<br><b>316-58-0252</b>  |  | 17. INFORMANT<br><b>7905 Broadway</b><br><b>Geisen Funeral Home Merrillville, Ind</b>           |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9531</b> IMMEDIATE CAUSE (a) <b>ASPHYXIATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) <b>SCHIZOPHRENIA CHRONIC</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b> |                        |   |   |   |  |   |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b></b>  |                        |   |   |   |  |   |  |  |  |                |  |
| 19a. DATE OF OPERATION<br><b></b>   |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b></b>  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>4 21 19 81</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>PLASTIC + ETHER OVER FACE</b>   |  |   |  |  |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>HOME</b>  |   | 21f. LOCATION<br>STREET <b>500 W. MONTGOMERY</b> CITY OR TOWN <b>ROCKVILLE</b> COUNTY <b>MONTGOMERY</b> STATE <b>MD</b>                                     |  |   |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>       |                        |   |   |   |  |   |  |  |  |                |  |
| ACTUAL SIGNATURE<br><b>Francis C. Mayle</b>   |                        |   |   | TITLE (SPECIFY)<br><b>Dept</b>  |  | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>4/21/81</b>                    |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>FRANCIS C. MAYLE</b>   |                        |   |   | ADDRESS<br><b>8200 Wisconsin Ave Bethesda, MD</b>   |  |   |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                        | 23b. DATE<br><b>April 24, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calumet Park Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Merrillville</b> COUNTY <b>Indiana</b> STATE <b>INDIANA</b>    |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey</b><br>Homes, P.A. ADDRESS <b>Bethesda, Maryland</b>   |                        |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 27 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony K. Brady</b>   |  |  |  |                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |                                    |   |   |  |          |  |  |
|--|--|--|---|---|------------------------------------|---|---|--|----------|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |   | 8111080   |                                    |   |   |  |          |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |   |                                    | 2a. DATE OF DEATH MONTH DAY YEAR  |   |  | 2b. HOUR |  |  |
| Freeman A Willet   |  |  |   |   |                                    | 4 22 81   |   |  | 6 A M    |  |  |
| 3 SEX  |  | 4 RACE   |   | 5. DATE OF BIRTH MONTH DAY YEAR   |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS                              |  |
| MALE   |  | WHITE  |   | 9 17 10   |                                    | 70  |   | MONTHS DAYS  |          | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH   |   |  |          |  |  |
| NEW YORK   |  | U.S.A  |   |   |                                    | MONTGOMERY MD.  |   |  |          |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                                    | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)                 |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |          |  |  |
| Bethesda   |  | Suburban Hospital  |   |   |                                    | Retired-DC TRANSIT  |   |  |          |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |                                    |   |   |  |          |  |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS  |          |  |  |
| MD   |  | MONT.  |   | SILVER SPRING   |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |   | 10103 PIERCE DRIVE   |          |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |                                    |   |   |  |          |  |  |
| ALBERT H. WILLET   |  |  |   | ANNA ALLEN  |                                    |   |   |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   | 16b. SOCIAL SECURITY NO   |                                    | 17. INFORMANT ADDRESS   |   |  |          |  |  |
| YES  |  |  |   | 1927-1930   |                                    | 578-10-5817 THELMA F. WILLET, 10103 PIERCE DR S.E.                            |   |  |          |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |   |                                    |   |   |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Congestive Heart Failure   |  |  |   |   |                                    |   |   |  |          | Five   |  |
| 4429 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis   |  |  |   |   |                                    |   |   |  |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Compensated 2b leg  |  |  |   |   |                                    |   |   |  |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |                                    |   |   |  |          |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                    | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |  |  |
| 4/22/81  |  |  | Septic Pseudomonas  |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |   |                                    | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |          |  |  |
|  |  |  | P.M. 19   |   |                                    |   |   |  |          |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |  |          |  |  |
|  |  |  | December 19 1980  |   |                                    | April 22 19 81  |   |  |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 21 19 81 to April 22 19 81, that (I) (we) last saw the deceased alive on April 21 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                                    |   |   |  |          | 22c. DATE SIGNED                             |  |
| 22b. SIGNATURE   |  |  |   |   |                                    |   |   |  |          | 22c. DATE SIGNED                             |  |
| Thelma F. Willet   |  |  |   |   |                                    |   |   |  |          | 4/22/81                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   | 22e. ADDRESS  |                                    |   |   |  |          |  |  |
|  |  |  |   | 8218 Sherman Ave. Beth. Md.   |                                    |   |   |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |          |  |  |
| Burial   |  |  | April 24, 1981  |   | Fort Lincoln Cemetery              |   | Baltimore MD                            |  |          |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  | 24b. ADDRESS  |   |                                    | 25a. DATE REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |          |  |  |
| Takoma Funeral Home  |  |  | 254 Connell St. NW DC   |   |                                    |   |   |  |          |  |  |



ALL

WTS

New York

U.S.A.

Washington

SECRET

THIS PAGE DOES

NOT CONTAIN

ANY

OF

ANY

AND

THAT

IT

WAS

NOT TO BE DISCLOSED TO ANY OTHER PERSON OR ORGANIZATION

EXCEPT BY AUTHORITY

OF THE SECRETARY OF DEFENSE

OR THE SECRETARY OF THE ARMY

OR THE SECRETARY OF THE NAVY

OR THE SECRETARY OF THE AIR FORCE

OR THE SECRETARY OF THE MARINE CORPS

OR THE SECRETARY OF THE COAST GUARD

OR THE SECRETARY OF THE NATIONAL GUARD

OR THE SECRETARY OF THE NATIONAL RESERVE

OR THE SECRETARY OF THE NATIONAL DEFENSE

GROUP 1 - EXCLUDED FROM AUTOMATIC DOWNGRADING AND DECLASSIFICATION

EXCEPT BY AUTHORITY OF THE SECRETARY OF DEFENSE

Cleared by: Francis C. Mayle, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | 3 SEX   |  | 4 RACE  |  |
| ALBERTA F. WILLIS  |  | F   |  | W   |  |
| 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |
| 1 9 1892   |  | 88 89 YRS.  |  | Va.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |
| U.S.A.   |  |   |  | MONTGOMERY COUNTY MD.   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |
| BETHESDA   |  | BETHESDA HEALTH CENTER  |  | MILLINER  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| MD.  |  | MONTG.  |  | ROCKVILLE   |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                 |  |
| Joseph FOLEY   |  | Nancy MILLER  |  | ---   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT (or daughter) 3406 Nimitz Rd.,   |  | 17b. KIND OF BUSINESS OR INDUSTRY   |  |
| 577-10-3219  |  | Laurie B. Willis-Kensington, Md. 20795  |  | Jelleff's   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u>   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u>  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma left kidney</u>  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 2-11</u> , 19 <u>81</u> , to <u>4-12</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2-11</u> , 19 <u>81</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| John M. Kymmer   |  | MD  |  | 4/12/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |
| John M. Kymmer   |  | 7801 Norfolk Ave Bethesda, Md 20814   |  | Cremation   |  |
| 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 4-14-1981  |  | Metropolitan Crematory Alex., Alex., Va.  |  |   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.   |  | APR 16 1981   |  | [Signature]   |  |

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 0 8 2  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Dorothy L. WILSON</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 6 1981</b>   |  | 2b. HOUR<br><b>10:12A</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 8 1927</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Gaithersburg</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Knight</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie E. Frazier</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>162 22 9294</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Cecil M. Wilson See item 13</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adverse CA &amp; Thrombocytopenia</b><br>1991<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last:<br>(b) <b>Cross sensitivity &amp; leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>15°</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 30</b> , 19 <b>81</b> , to <b>April 6</b> , 19 <b>81</b> that (I) (we) lost<br>saw the deceased alive on <b>April 6</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. If (we) did (didn't) view the body after death          |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Mark H. Brown</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Apr. 6 1981</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark H. Brown</b>  |  |   |  | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>APR 14 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Penn Memorial Gardens</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hanover York Pennsylvania</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Home</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |  |





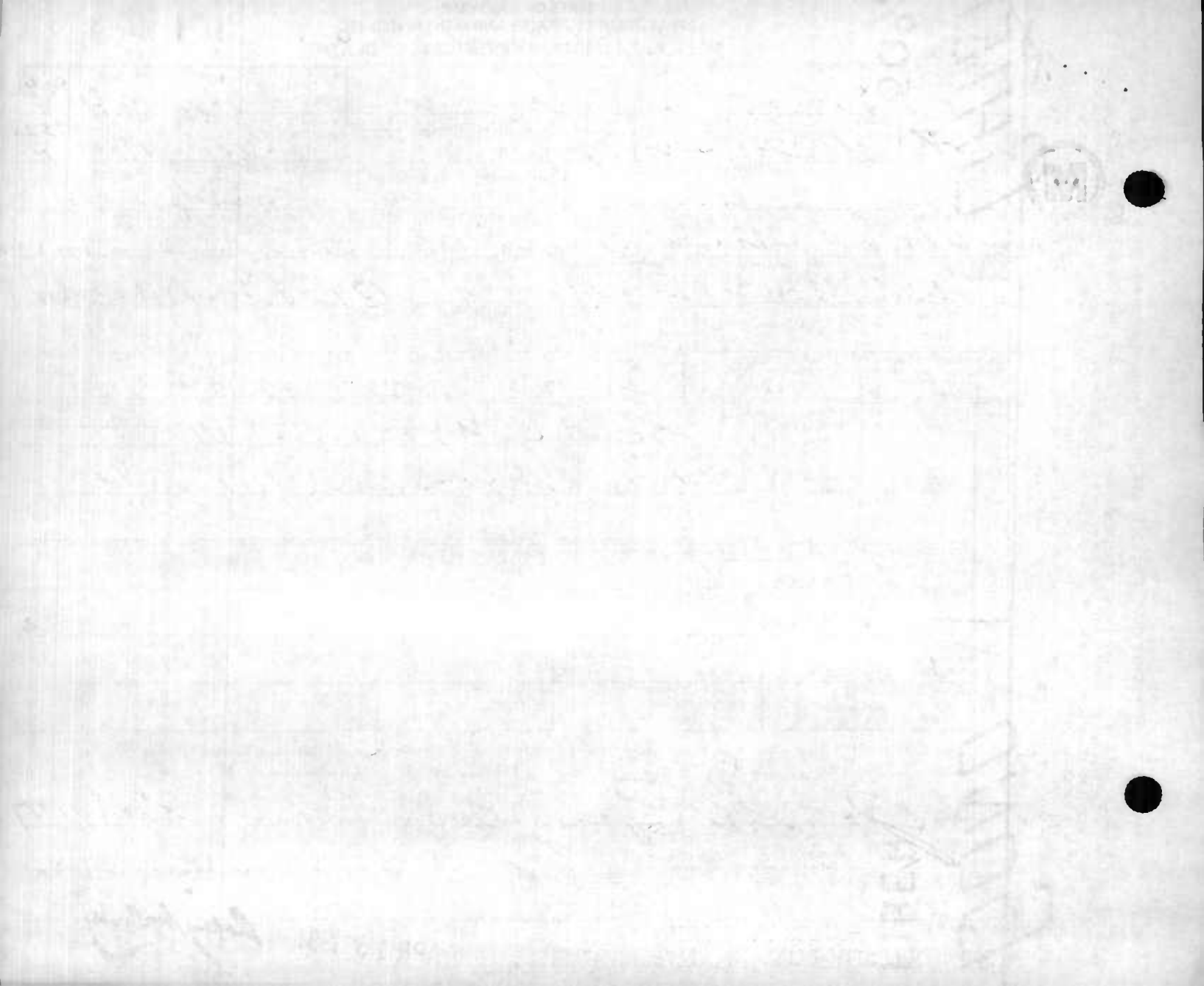
There is a [illegible] of [illegible]  
[illegible] [illegible]

W. H. [illegible]  
[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR FILES OF THE MEDICAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |   |  |   |                               |   |  |  |               | REG. NO. 11083                               |  |
|--|------------------|---|--|---|-------------------------------|---|--|--|---------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jamar W. Wilson</b>   |                  |   |  |   |                               | 2a. DATE KNOWN OF DEATH <b>April 11, 1981</b>   |  | 2b. MONTH DAY YEAR   |               | 2c. HOUR MIN.                                |  |
| 3. SEX <b>M</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Dec. 4, 1959</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>21 YRS.</b>  | 7. IF UNDER 1 YR. MONTHS DAYS | 7. IF UNDER 24 HRS. HOURS MIN.  | 2c. DATE PRONOUNCED DEAD <b>April 11, 1981</b> |  | 2d. HOUR MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>                            |  |  |               |  |  |
| 10. CITY OR TOWN OF DEATH <b>Olney</b>   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mont. General Hosp.</b> |  |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STAFF SPECIALIST</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>VITRO IND.</b>  |               |  |  |
| 13a. STATE <b>MD</b>   |                  |   |  |   |                               | 13b. CITY OR TOWN <b>Mont. Rockville</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |               | 13d. STREET ADDRESS <b>12908 Marviana Dr</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>GLEN WILSON</b>  |                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>VESTA YATES</b>  |                               |   |  |  |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW II</b>   |                  |   |  | 16b. SOCIAL SECURITY NO. <b>334-16-8072</b>   |                               | 17. INFORMANT <b>BERYL WILSON</b>   |  | 17. ADDRESS <b>SAME AS 13</b>  |               | 17. RELATIONSHIP <b>WIFE</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>4291<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Yrs</b>  |                  |   |  |   |                               |   |  |  |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>   |                  |   |  |   |                               |   |  |  |               |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                               |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |               |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |   |  |  |               |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |   |  |  |               |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |                               |   |  |  |               |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |                  |   |  | TITLE (SPECIFY) <b>Dep.</b>   |                               |   |  | MEDICAL EXAMINER   |               |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>  |                  |   |  | ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>   |                               |   |  |  |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                  | 23b. DATE <b>4/15/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>ARLINGTON VIRGINIA</b>                  |  |  |               |  |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>  |                  |   |  |   |                               | 25a. DATE REC'D. BY REGISTRAR <b>APR 15 1981</b>                                      |  |  |               |  |  |
| 500 UNIVERSITY BLVD., W., SILVER SPRING, MD. 20901   |                  |   |  |   |                               |   |  |  |               |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at a

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |   |  |   |
|--|--|--|--|---|--|---|--|--|--|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.   |   |  |  |  |   |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM C. WINE LAND</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 12, 1981</b>   |   |  |  |  | 2b. HOUR <b>1:15 P.M.</b>   |  |   |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Dec 5 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Louisiana</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.               |  |  |  |   |  |   |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Physicist</b> |  |   |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Sil. Spring</b>  |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS <b>10304 Eastwood Avenue,</b>                  |  |  |   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>William Wineland</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Annie Suhr</b>  |   |  |  |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) <b>---</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO. <b>215-44-3112</b>  |   | 17. INFORMANT (wife) ADDRESS <b>Frances Wineland-(same as 13e)</b> |  |  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4415</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Shock</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>Ruptured abdominal aortic aneurysm</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>1 day</b><br><b>1 month</b> |  |  |  |   |  |   |  |  |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>   |  |  |  |   |  |   |  |  |  |   |  |   |
| 19a. DATE OF OPERATION <b>3-6-81</b>   |  |  |  |   |  |   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured abdominal aneurysm</b> | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |  |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-6-81</b> to <b>4-12-81</b> , that (I) (we) last saw the deceased alive on <b>4-12-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.  |  |  |  |   |  |   |  |  |  |   |  |   |
| 22b. SIGNATURE <b>Michael D Sullivan</b> DEGREE <b>MD</b>  |  |  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED <b>4-12-81</b>                    |  |   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL DSULLIVAN MD</b>  |  |  |  |   | 22e. ADDRESS <b>1811 Prince Philip Dr Olney Md</b>   |   |  |  |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>4-15-1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Burtonsville Montgomery Md.</b>   |  |  |  |   |  |   |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b><br><b>8434 Georgia Ave., S.S. Md.</b>  |  |  |  |   | 25a. DATE RECD. BY REGISTRAR <b>APR 20 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                      |  |  |   |  |   |

RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LAURA Bryn WINSLOW   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 11, 1981                         |  | 2b. HOUR<br>12:15 PM  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 27 1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Norway  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>15 East Lenox St. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Mont.  | 13c. CITY OR TOWN<br>Chevy Chase   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Helmer H. Bryn   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Grilstad               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-24-4938  |   | 17. INFORMANT<br>ADDRESS<br>Laura Winslow, Dtr., same as item 13.              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Squamous Carcinoma - Lung with brain</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>and bone metastasis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 months.</u>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 April</u> , 19 <u>81</u> , to <u>11 April</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>10 April</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><u>Richard M. Huffman M.D.</u>   |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>11 April '81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard M. Huffman, M.D.  |  | 22e. ADDRESS<br>3301 New Mexico Ave., N.W. Wash., D.C.  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>4/16/1981   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Hill Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.                 |   |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.<br>NAME ADDRESS<br>5130 Wisc. Ave., N.W. Wash., D.C.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 21 1981                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>  |

REPORT OF THE  
SURVEY

OF THE  
LANDS

IN THE

STATE OF

NEW YORK

AND

THE

ADJACENT

WATERS

OF THE

LAKE

AND

THE

ADJACENT

WATERS

OF THE

LAKE

AND

THE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 1 0 8 6   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Louise Cecelia Wolff  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 28, 1981   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 19, 1996   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Chevy Chase Conv. Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Bethesda   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Montgomery  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Hoxie  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>267-41-2546  |  | 17. INFORMANT<br>ADDRESS<br>Louise Yeatman, Daughter, Same as #13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>coronary heart failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>atherosclerotic heart disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 min</u><br><u>3 days</u><br><u>10 years</u> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>chronic asthmatic bronchitis</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1, 1980</u> to <u>April 28, 1981</u> , that (I) <del>(we)</del> lost<br>saw the deceased alive on <u>April 28, 1981</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>(we)</del> did <del>(did not)</del> view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Thomas F. O'Connor M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>April 29, 1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas F. O'Connor, M.D.  |  |   |  | 22e. ADDRESS<br>8218 Wisconsin Avenue, Bethesda, MD.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>April 30, 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 4 - 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Pumphrey</u>  |  |



*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHENT T. WONG</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 7, 1981</b>               |   |  | 2b. HOUR<br><b>5:20 PM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Asian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 2, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>China</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>China</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORKING LIFE)<br><b>Cook</b>                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>11907 Parklawn Dr #104</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>YAU L. WONG</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hai J. KAO</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-80-7634</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ming C. Wong Wife Same as item 13</b>                            |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe COPD, congestive heart failure</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Prerenal Azotemia</b> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 23, 1981</b> to <b>April 7, 1981</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |
| 23. SIGNATURE<br><b>Chengyong Wong Chen</b><br>23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MEIYING W. CHEN</b>   |  |   |  |   |  | DEGREE<br><b>M.D.</b><br>23b. ADDRESS<br><b>5505 WATERWAY TERRACE, Rockville, Maryland</b>      |  | 23c. DATE SIGNED<br><b>April 7, 1981</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   | 23b. DATE<br><b>April 11, 1981</b>                                     |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1981</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

37

0



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |   |  |   |  |  |  |
|---|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRMA C WORCESTER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 28, 1981</b>                  |   | 2b. HOUR<br><b>4 45 A</b><br>M                                    |  |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 13, 1914</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b><br>YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Scotland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACIL. GIVE ST. REF. ADDRESS)<br><b>Suburban Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Bethesda</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8508 Woodhaven Blvd.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Schmidt</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Christina Villhardt</b>   |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>050-22-6225</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Patricia Lore (Same as 13e)</b>    |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of Breast</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 mo</b><br><b>8 yr</b> |  |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/27/81</b> , 19____, to <b>4/28/81</b> , 19____, that (I) (we) lost saw the deceased alive on <b>4/27/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-28-81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeremy V. Cooke</b>   |  |  | 22e. ADDRESS<br><b>10400 Conn. Ave. Kensington MD</b>                         |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE<br><b>April 30, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Feasterville PA</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>   |  |  | FIRM<br><b>Homes, P.A., Bethesda, Maryland</b>                                |   |   | 25a. DATE BY REG. STRAR<br><b>MAY 1 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |

MEDICAL CERTIFICATION

29

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |           |  |   |                  |  |  |                                 | 8 1 1 0 8 9   |  |                     |  |                  |                                      |  |  |  |  |
|--|--|--|-----------|--|---|------------------|--|--|---------------------------------|---|--|---------------------|--|------------------|--------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |           |  |   |                  |  |  |                                 | REG. NO.  |  |                     |  |                  |                                      |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |           |  | FIRST MIDDLE LAST   |                  |  |  |                                 | 2a. DATE OF DEATH MONTH DAY YEAR  |  |                     |  | 2b. HOUR         |                                      |  |  |  |  |
| Anna   |  |  |           |  | C. Zetts  |                  |  |  |                                 | April 22 1981   |  |                     |  | :30 A.M.         |                                      |  |  |  |  |
| 3. SEX   |  |  | 4. RACE   |  |   | 5. DATE OF BIRTH |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |   |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS. |                                      |  |  |  |  |
| Female   |  |  | Caucasian |  |   | April 25, 1891   |  |  | 89 YRS.                         |   |  | MONTHS DAYS         |  | HOURS MIN.       |                                      |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |           |  | 7b. CITIZEN OF WHAT COUNTRY?  |                  |  |  |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                     |  |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |
| Tennessee  |  |  |           |  | United States   |                  |  |  |                                 |   |  |                     |  |                  | Montgomery County, MD.               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |  |  |                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                     |  |                  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |  |
| Silver Spring  |  |  |           |  | Holy Cross Hospital   |                  |  |  |                                 | Housewife   |  |                     |  |                  | Home                                 |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |           |  |   |                  |  |  |                                 | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                  |                                      |  |  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |  |           |  |   |                  |  |  |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 5101 River Rd.      |  |                  |                                      |  |  |  |  |
| 14. FATHER'S NAME  |  |  |           |  |   |                  |  |  |                                 | 15. MOTHER'S MAIDEN NAME  |  |                     |  |                  |                                      |  |  |  |  |
| FIRST MIDDLE LAST  |  |  |           |  |   |                  |  |  |                                 | FIRST MIDDLE LAST   |  |                     |  |                  |                                      |  |  |  |  |
| Clemence Stuecker  |  |  |           |  |   |                  |  |  |                                 | Gertrude Shulte   |  |                     |  |                  |                                      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |           |  | 16b. SOCIAL SECURITY NO.  |                  |  |  |                                 | 17. INFORMANT   |  |                     |  |                  |                                      |  |  |  |  |
| No   |  |  |           |  | 577-26-0244   |                  |  |  |                                 | Mary C. Curry 9700 Ardmore Rd. Kensington, Maryland   |  |                     |  |                  |                                      |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br>4810<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Right upper lobe pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |  |  |           |  |   |                  |  |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>immediate</i><br><i>3 days</i>   |  |                     |  |                  |                                      |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetic Mellitus, Arterio Sclerotic vascular disease</i>   |  |  |           |  |   |                  |  |  |                                 |   |  |                     |  |                  |                                      |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  |  |  |                                 | 20a. AUTOPSY?   |  |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                  |                                      |  |  |  |  |
|  |  |  |           |  |   |                  |  |  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                  |                                      |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                  |  |  |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |                     |  |                  |                                      |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                  |  |  |                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                     |  |                  |                                      |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1975</i> , 19____, to <i>4/22/81</i> , 19____, that (I) (we) last saw the deceased alive on <i>4/21/81</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |           |  |   |                  |  |  |                                 |   |  |                     |  |                  |                                      |  |  |  |  |
| 22b. SIGNATURE   |  |  |           |  |   |                  |  |  |                                 | DEGREE  |  |                     | 22c. DATE SIGNED   |                  |                                      |  |  |  |  |
| <i>Jeremy V. Cooke M.D.</i>  |  |  |           |  |   |                  |  |  |                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |                     | April 22, 1981   |                  |                                      |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE & PRINT)   |  |  |           |  |   |                  |  |  |                                 | 22e. ADDRESS  |  |                     |  |                  |                                      |  |  |  |  |
| Jeremy V. Cooke, M.D.  |  |  |           |  |   |                  |  |  |                                 | 10400 Connecticut Ave., Kensington, Maryland  |  |                     |  |                  |                                      |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  |           |  | 23b. NAME OF CEMETERY OR CREMATORY  |                  |  |  |                                 | 23c. LOCATION   |  |                     |  |                  |                                      |  |  |  |  |
| Burial   |  |  |           |  | April 24 1981   |                  |  |  |                                 | Arlington National, Virginia STATE  |  |                     |  |                  |                                      |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  |           |  |   |                  |  |  |                                 | 25a. DATE REC'D. BY REGISTRAR   |  |                     | 25b. REGISTRAR'S SIGNATURE                                     |                  |                                      |  |  |  |  |
| Robert A. Pumphrey, Bethesda, Maryland   |  |  |           |  |   |                  |  |  |                                 | APR 27 1981   |  |                     | <i>Robert A. Pumphrey</i>                                      |                  |                                      |  |  |  |  |

MEDICAL CERTIFICATION

29

BP



